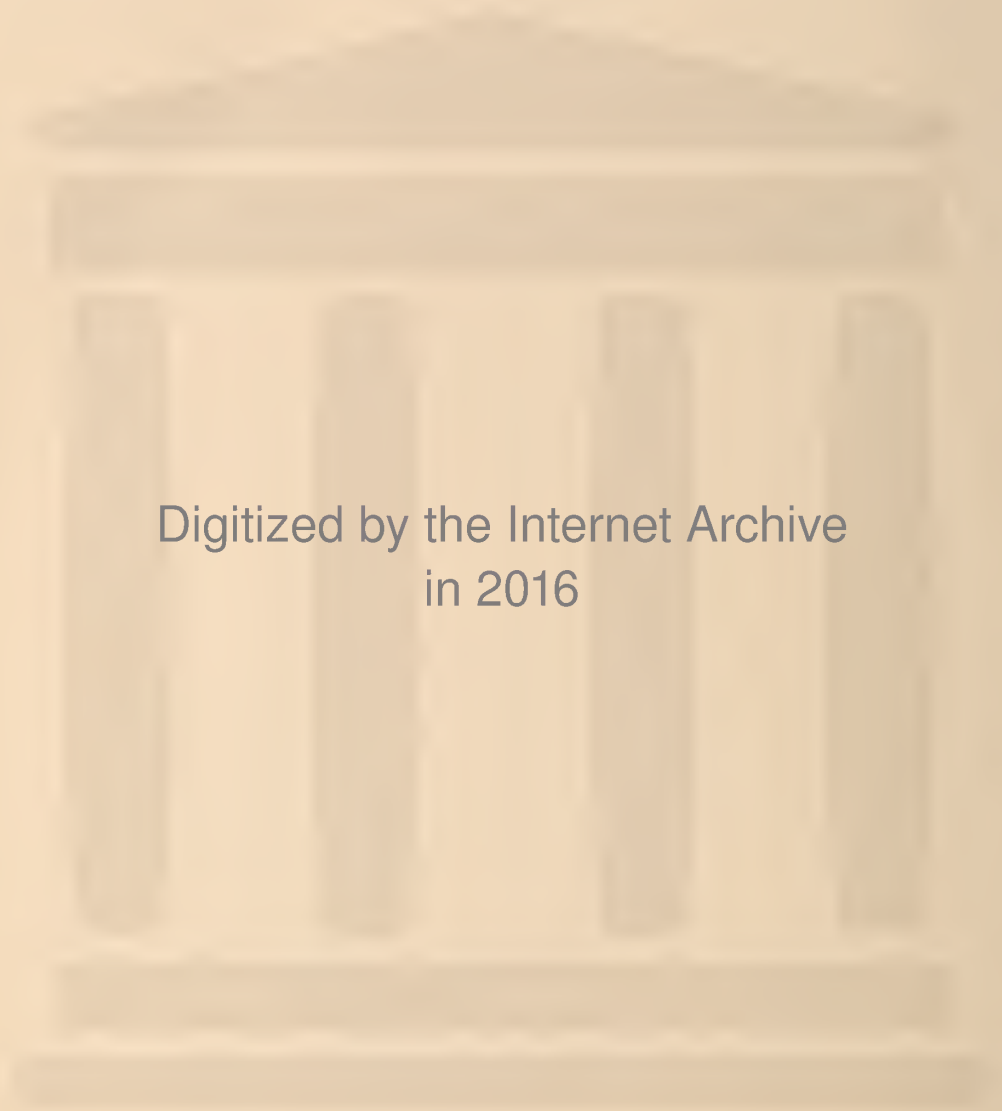
The New York
Academy of Medicine

By Exchange


Digitized by the Internet Archive
in 2016

https://archive.org/details/journalofflorida39unse

The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXIX JULY, 1952 No. 1

JUL - 1952
LIBRARY

IN THIS ISSUE

New Concept of Baby Feeding
Walter W. Sackett, Jr., and Ben J. Sheppard

Prolapse of Gastric Mucosa
Sidney Stillman

Allergy Survey of Florida
Clarence Bernstein and Solomon D. Klotz

Dr. Henry Perrine
Versatile Florida Pioneer
An Editorial

OFFICIAL PUBLICATION OF THE
FLORIDA MEDICAL ASSOCIATION

In hay fever

LIBRARY
JAN 28 1954
291366

BENADRYL (diphenhydramine hydrochloride, Parke-Davis) gives rapid—and sustained—relief to patients distressed by hay fever symptoms. By alleviating sneezing, nasal discharge, lacrimation, and itching, this outstanding antihistaminic has enabled many thousands of patients to pass hay fever seasons in comfort.

BENADRYL'S reputation stems from its *clinical performance.* Each year, as the pollen count rises, the benefits derived from this effective antihistaminic are further emphasized. BENADRYL Hydrochloride is available in a variety of forms—including Kapseals®, 50 mg. each; Capsules, 25 mg. each; Elixir, 10 mg. per teaspoonful; and Steri-Vials®, 10 mg. per cc. for parenteral therapy.

BENADRYL®

for a symptom-free season

MEDICAMENTA VERA · PD & CO.

Parke, Davis + Company

DETROIT, MICHIGAN

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

Volume XXXIX JULY, 1952 No. 1

CONTENTS

SCIENTIFIC ARTICLES

Further Observations on a New Concept of Baby Feeding, Walter W. Sackett, Jr., M.D., and Ben J. Sheppard, M.D. 21
Prolapse of the Gastric Mucosa into the Duodenum: Report of Eight Cases, Sidney Stillman, M.D. 25
Incidence of Heart Disease in School Children of Pensacola, Florida, Lieutenant John M. Packard, MC, USN, Lieutenant John S. Graettinger, MC, USN, and Captain Ashton Graybiel, MC, USN 30
A Note on New Drugs, "Miracle" and Otherwise, For Tuberculosis, Henry C. Sweany, M.D. 37
Allergy Survey of Florida in the Light of Present Knowledge, Clarence Bernstein, M.D., and Solomon D. Klotz, M.D. 38

ABSTRACTS OF MEDICAL ARTICLES

Drs. Frank J. Pyle and John M. McDonald 41

EDITORIALS AND COMMENTARIES

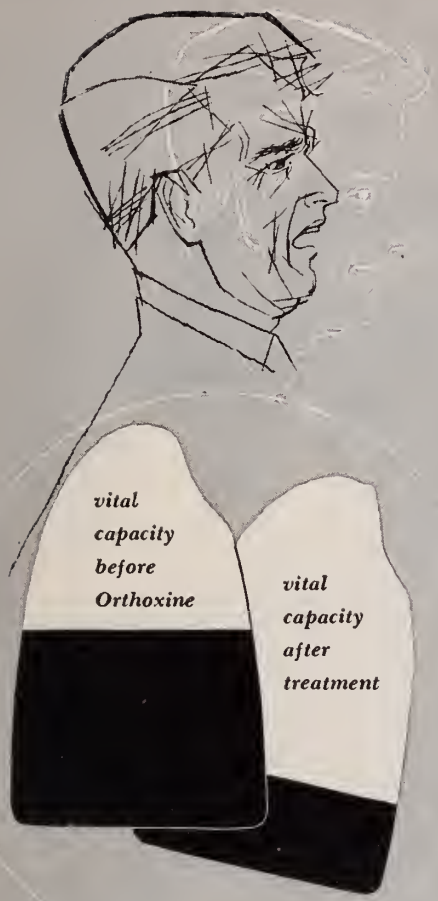
Dr. Henry Perrine, Versatile Florida Pioneer 45
Good Reading for Americans 50
The Changing Disease Pattern 51
Antituberculosis Drugs 51
Periodic Physical Examinations Required 52
Pointed Testimony 52

GENERAL FEATURES

Officers and Committees 42
From Our President 44
New Members 53
Your Blue Shield 53
Medical Officers Returned 53
Births and Deaths 53
State News Items 54
Component Society Notes 56
Wanted — For Sale 56
Obituaries 58
Woman's Auxiliary 60
Books Received 61
Schedule of Meetings 69
List of County Medical Societies, Presidents and Secretaries 70

This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Actof Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



an answer to asthma

Q Is there a sympathomimetic agent that will give relief from asthma without causing vasopressor and psychomotor stimulation?

A Orthoxine Hydrochloride provides bronchodilatation with minimal vasopressor and psychomotor stimulation. By modifying the configuration of a sympathomimetic amine molecule, the action of Orthoxine has been centered mainly upon bronchodilatation, thereby minimizing side-effects arising from vasopressor or psychomotor-stimulating activity.

Orthoxine*

HYDROCHLORIDE

BRAND OF METHOXYPHENAMINE

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Bottles of 100 and 500 tablets.

Orthoxine Hydrochloride (100 mg.) tablets contain *beta-(ortho*-methoxyphenyl)-isopropyl-methylamine hydrochloride, a bronchodilator and antispasmodic.

For Adults: ½ to 1 tablet (50 to 100 mg.)

For Children: half the dose

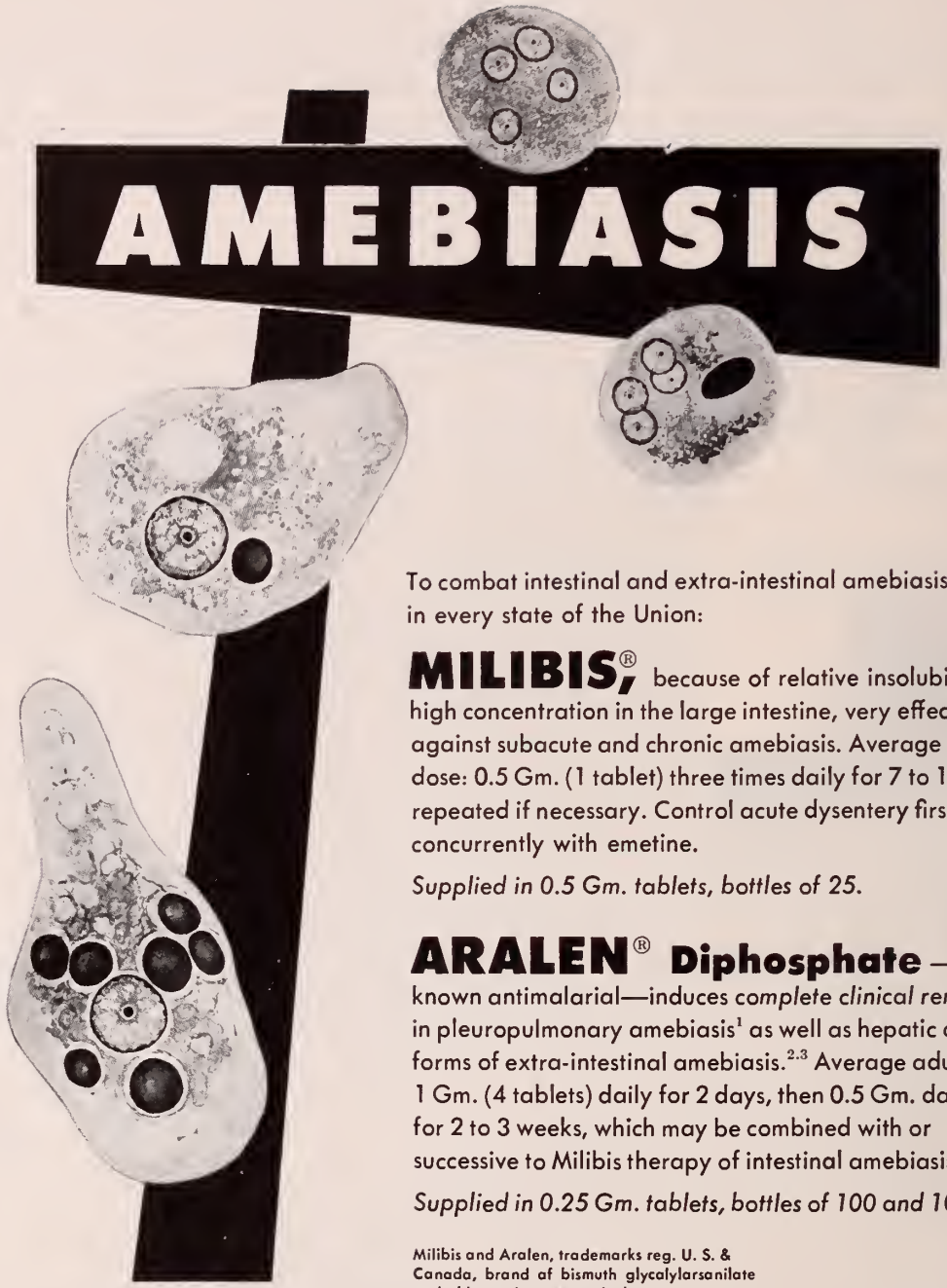
For Both: Repeat every 3 to 4 hours as required

**Trademark, Reg. U. S. Pat. Off.*

Upjohn *Medicine . . . Produced with care . . . Designed for health*

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

AMEBIASIS



To combat intestinal and extra-intestinal amebiasis, found in every state of the Union:

MILIBIS,® because of relative insolubility, assures high concentration in the large intestine, very effective against subacute and chronic amebiasis. Average adult dose: 0.5 Gm. (1 tablet) three times daily for 7 to 10 days, repeated if necessary. Control acute dysentery first or concurrently with emetine.

Supplied in 0.5 Gm. tablets, bottles of 25.

ARALEN® Diphosphate —the well known antimalarial—induces *complete clinical remission* in pleuropulmonary amebiasis[1] as well as hepatic and other forms of extra-intestinal amebiasis.[2,3] Average adult dose: 1 Gm. (4 tablets) daily for 2 days, then 0.5 Gm. daily for 2 to 3 weeks, which may be combined with or successive to Milibis therapy of intestinal amebiasis.

Supplied in 0.25 Gm. tablets, bottles of 100 and 1000.

Milibis and Aralen, trademarks reg. U. S. & Canada, brand of bismuth glycalylarsanilate and chloraquine, respectively.

1. Lindsay, A. E., Gassard, W. H., and Chapman, J. S.: *Dis. Chest*, 20:533, Nov., 1951.
2. Canan, N. J., Jr.: *Am. Jour. Med.*, 6:309, Mar., 1949.
3. Emmett, J.: *J.A.M.A.*, 141:22, Sept. 3, 1949.

Illustrated brochure on request.

WINTHROP-STEARNS INC.
New York 18, N. Y. Windsor, Ont.

"PREMARIN"®

Highly effective • Well tolerated • Imparts a feeling of well-being

"PREMARIN"

The menopausal patient
welcomes the sense of well-being
imparted by "Premarin."

"PREMARIN"

Estrogenic Substances (water-soluble)

"PREMARIN"

also known as Conjugated Estrogens (equine)

"PREMARIN"

5209

AYERST, McKENNA & HARRISON Limited • New York, N. Y. • Montreal, Canada

WYDASE IN OFFICE PRACTICE

Part of a series on its everyday use

Wyeth®

Reduction of Simple Fractures

In the reduction of simple fractures, Wydase added to a local anesthetic solution*:

1. Hastens onset of anesthesia
2. Promotes wide diffusion of injected anesthetic
3. Reduces swelling, thus permitting snug-fitting cast

Supplied: Vials of 150 and 1500 turbidity-reducing (TR) units.

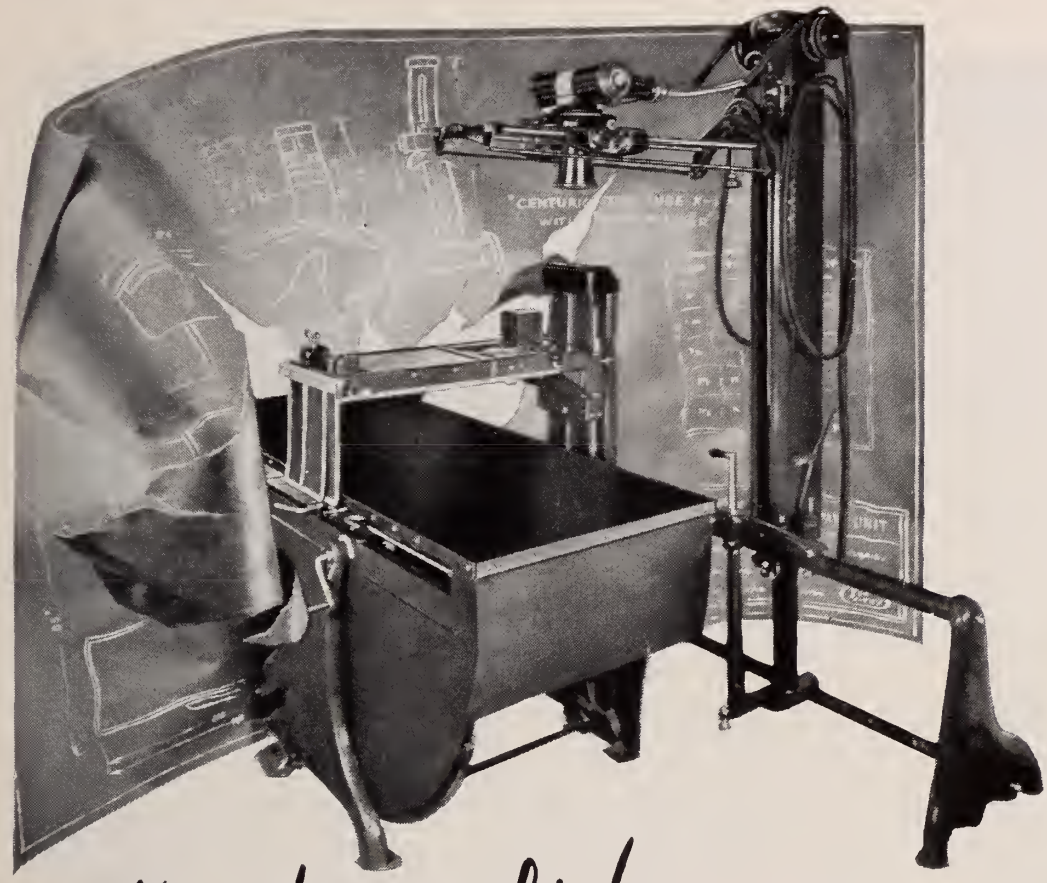
**150 TR units when added to 25 cc. of anesthetic usually suffices. See package circular.*

Lyophilized

WYDASE®

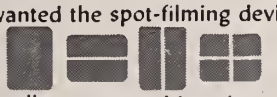
Hyaluronidase Wyeth

Wyeth Incorporated • Philadelphia 2, Pa.



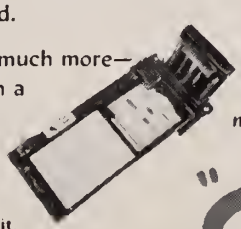
You asked for this!

You said you wanted a modern two-tube x-ray unit, with an efficient spot-filming device, and a separate over-table tubestand . . . *all this at a moderate price.* You wanted the table to be motor-driven for any angulation over the full range between Trendelenburg and vertical.

You wanted the spot-filming device to give you a selection of fields  (whole film, half film or four "spots").

Above all, you wanted it to be easy-to-operate (motor-driven, if possible) but that seemed too much to hope for at the price you had in mind.

Well, you get all that—and much more—in this two-tube "Centurion" X-Ray Unit with a floor-mounted tubestand. *and with the famous Picker motor-driven "Spotfilmer" built right into it.*



Your local Picker representative will be glad to tell you all about it.

PICKER X-RAY CORPORATION
25 South Broadway, White Plains, N. Y

Picker

"Centurion"
with motor-driven "Spotfilmer"

MIAMI 35, FLA., 2759 Coral Way

TAMPA 1, FLA., P. O. Box 3032

JACKSONVILLE, FLA., 422 W. Duval Street

Time for Mull-Soy Proven food for infants allergic to milk

Case history: 140 infants allergic to milk*

Symptoms: Vomiting, eczema, colic, diarrhea

Results: Almost immediate relief by eliminating milk and switching to Mull-Soy

Make Mull-Soy *your first choice* when establishing a hypoallergenic diet. Here is high content of unsaturated fatty acids, also essential nutritional requirements of protein, fat, carbohydrate and minerals. Mull-Soy contains no animal protein.

*Cleia, Norman W.: Cow's Milk Allergy In Infants, Ann. Allergy 9:195 — 1951

MULL-SOY®

EASY — To prescribe
—To take —To digest

a liquid, homogenized, vacuum packed
food for all patients allergic to milk

The **Borden** Company, Prescription Products Division, 350 Madison Ave., N. Y. 17

NEW 5-mg. Tablets of Cortone®

For accurate adjustment of Maintenance Dosage and for therapy in conditions responding to Low Dosage

RHEUMATOID ARTHRITIS

ADDISON'S DISEASE

ADRENOGENITAL SYNDROME

FOLLOWING BILATERAL ADRENALECTOMY

Advantages of 5-mg. Tablets

FLEXIBILITY—

Used alone or in conjunction with the 25-mg. tablets, the new 5-mg. tablets afford greater flexibility in adjusting dosage to the individual patient's requirements. Fluctuations in the natural course of rheumatoid arthritis may be better controlled.

ACCURACY—

Permit more accurate establishment of minimum maintenance doses, thus controlling symptoms more closely and further minimizing the incidence of undesirable physiologic effects.

ECONOMY—

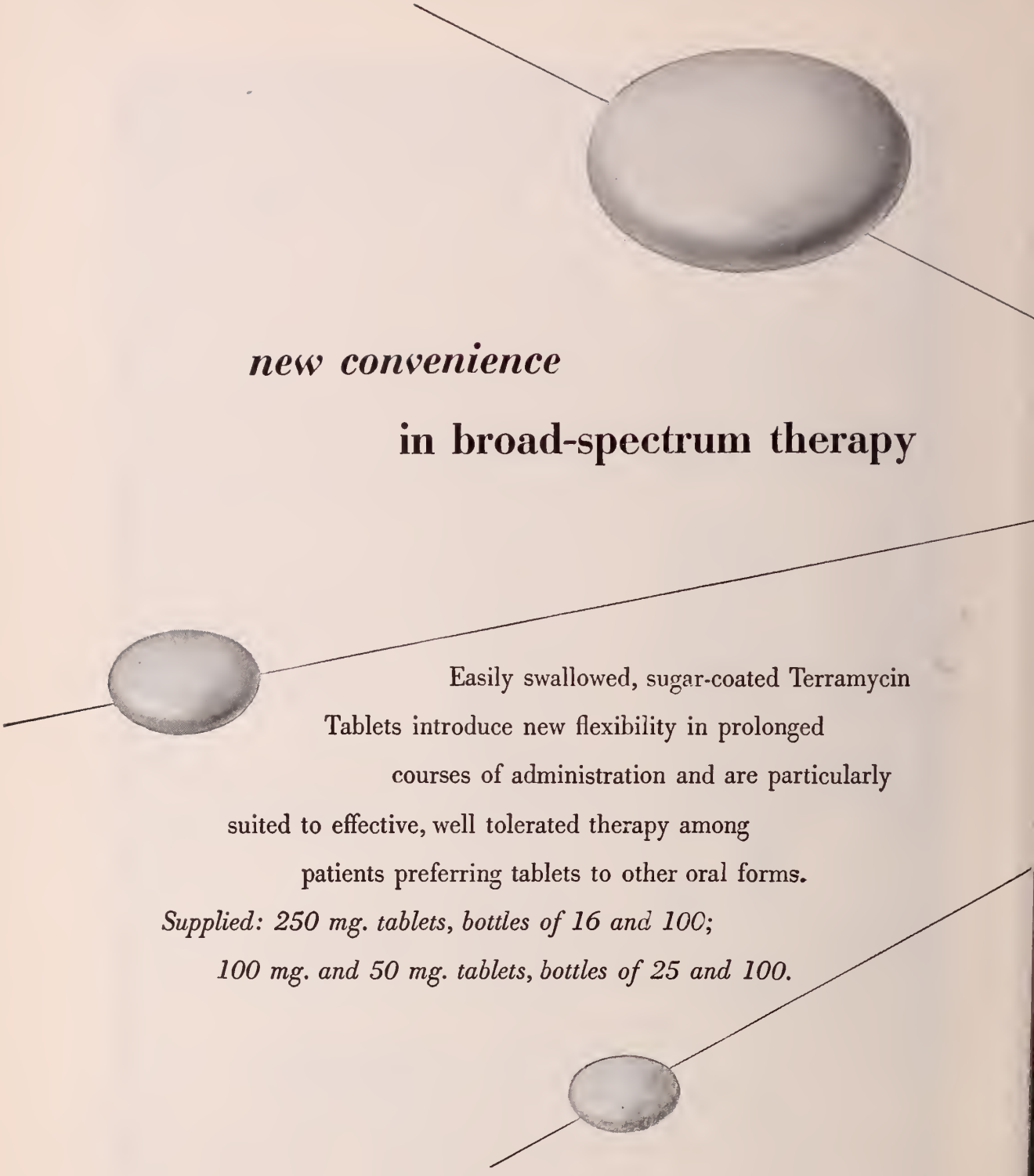
Prevent waste of CORTONE by more exact correlation between requirement and dosage.

Literature on Request

Cortone*
ACETATE
(CORTISONE ACETATE, MERCK)

*CORTONE *is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone. This substance was first made available to the world by Merck research and production.*

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY
In Canada: MERCK & CO. Limited—Montreal



new convenience

in broad-spectrum therapy

Easily swallowed, sugar-coated Terramycin Tablets introduce new flexibility in prolonged courses of administration and are particularly suited to effective, well tolerated therapy among patients preferring tablets to other oral forms.

Supplied: 250 mg. tablets, bottles of 16 and 100;
100 mg. and 50 mg. tablets, bottles of 25 and 100.

ANTIBIOTIC DIVISION, CHAS. PFIZER & CO., INC.
Brooklyn 6, N.Y.

Pfizer

CRYSTALLINE
Terramycin
AMPHOTERIC
SUGAR-COATED
tablets
RLD'S LARGEST PRODUCER OF ANTIBIOTICS

Still leading the family foursome

right through the menopause

ON ORAL ESTROGEN THERAPY
THAT IMPARTS *NO ODOR,*
NO TASTE, NO AFTERTASTE

FIRST, explain away her fears of the transition and assure her you can relieve her physical symptoms. Then, to prove your point, prescribe SULESTREX. Newest advance in the field, SULESTREX is as effective estrogen therapy as science has yet created. It is a *pure* estrone salt, stable and reproducible. There are no urinaceous ingredients to taint her breath or perspiration, even when therapy is intense, prolonged.

From two recent reports:

"*. . . a potent and effective oral estrogen with an extremely low incidence of nausea.*"[1]

"*. . . all patients noted a marked sense of well-being, and commented on their ability to resume normal activity with amazing vigor.*"[2]

Other studies have shown that you can expect constant, predictable results with SULESTREX with relatively few side-effects. Try this effective, esthetic therapy on your next menopausal patient. Available at all pharmacies in 0.75-, 1.5- and 3-mg. grooved tablets. Send for literature. Abbott Laboratories, North Chicago, Illinois. Abbott

1. *Perloff, Wm. H. (1951), Treatment of the Menopause. II. American J. Obst. & Gynec., 61:670, March.* 2. *Reich, W. J., et al. (1951), A Recent Advance in Estrogen Therapy. I. American J. Obst. & Gynec., 62:427, August.*

Sulestrex TRADE MARK

Piperazine tablets

(PIPERAZINE ESTRONE SULFATE, ABBOTT)

"...particularly beneficial in the treatment of hay fever."[1]

Because CHLOR-*TRIMETON*® maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"[2] it is a drug of choice for hay fever patients.

CHLOR-*TRIMETON*
maleate

1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26. 1950.

Schering CORPORATION
BLOOMFIELD, NEW JERSEY

CHLOR-*TRIMETON*

SCHERING

MEAT... and the Cholesterol Content of the Diet

An essential constituent of human tissue, contributing to the normal functioning of all cells, cholesterol has been widely discussed as a factor in the etiology of atherosclerosis. Yet this lipid is required in many metabolic processes, and, furthermore, evidence is lacking that withholding cholesterol from the dietary is effective in preventing atherosclerosis.

In a recent plea for a return to the basic fundamentals of nutrition in the prophylaxis of atherosclerosis, it was emphasized that to eliminate cholesterol from the diet would mean to eliminate such animal foods as meat, milk, eggs, etc.* However, nutritionists are unanimous in asserting that these protective foods contain basic essential nutrients required for good nutrition and that to deny them would be "equivalent to the negation of practically all that nutrition science has taught us in the past."

According to these authors,* elimination of animal foods from the diet to prevent the development of atherosclerosis is unjustified on the basis of present day knowledge. They state that "there certainly is no evidence that meatless, milkless, and eggless diets should be recommended as desirable to the general public."

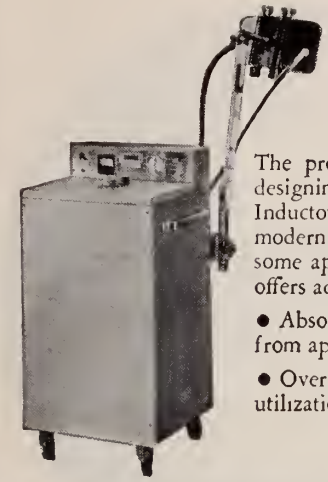
Meat, America's favorite protein food, always has been and continues to be an important dietary source of biologically complete protein, B vitamins, and iron. Few indeed are the conditions in which its use must be interdicted.

---

*Hegsted, D. M.; Mann, G. V., and Stare, F. J.: Comments on Cholesterol, Editorial, Postgrad. Med. *11*:454 (May) 1952.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute
Main Office, Chicago...Members Throughout the United States



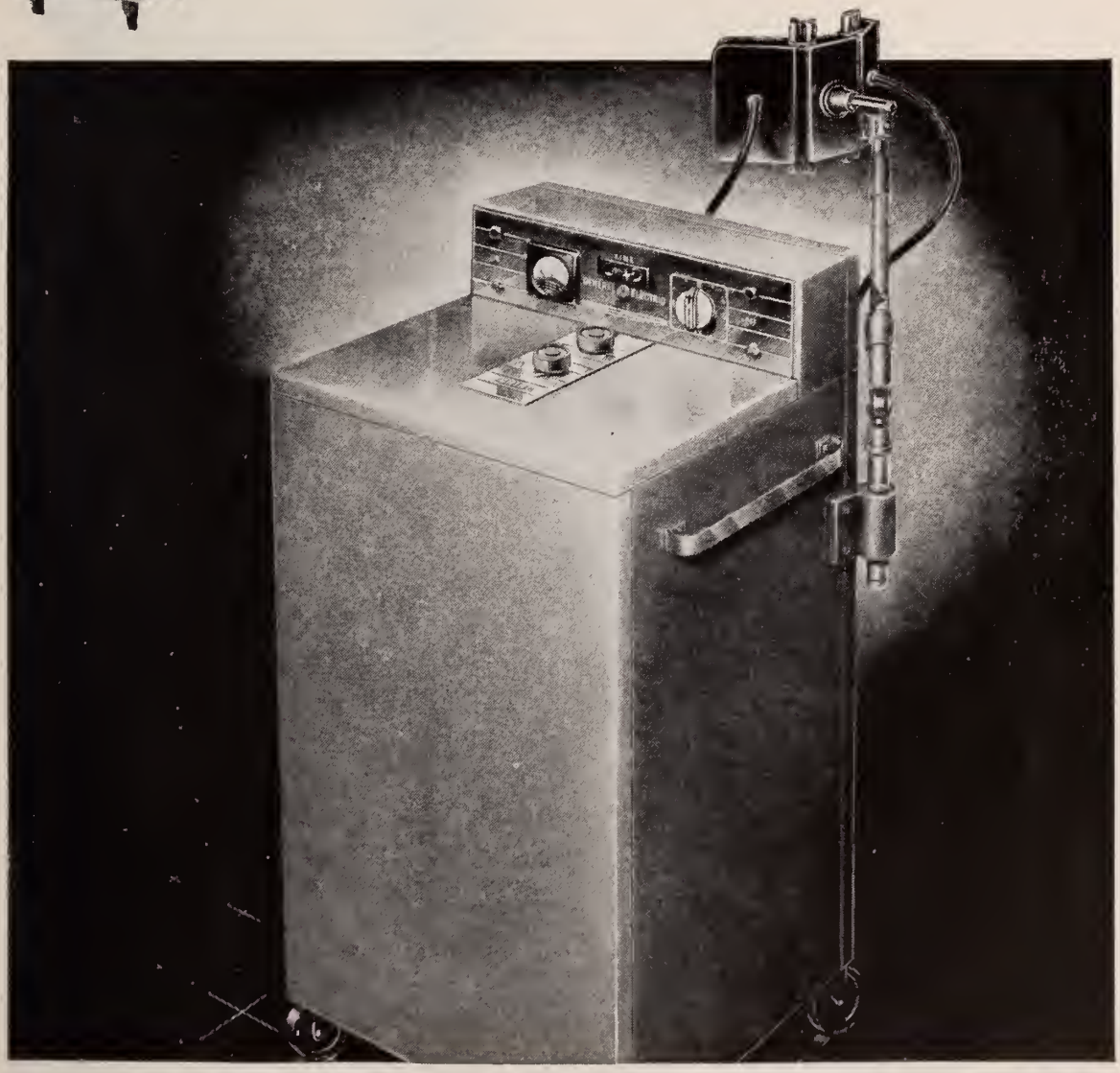
General Electric announces... a new, improved Inductotherm

The product of complete restyling and redesigning, General Electric's new Model F Inductotherm meets every requirement for modern diathermy technics. More than handsome appearance, this scientific development offers advanced features like these:

- Absolute crystal control limits variation from approved frequency to less than 0 05%.
- Over 200 watt output — for most efficient utilization of induction heating methods.
- Provision for three types of electrodes — contour, cable and air-spaced.
- Surgical facilities, now an integral part of the unit, for all medium and light technics.

Ask your GE x-ray representative for all the facts on the Model F, the Inductotherm apparatus that *fully* meets today's needs.

GENERAL ELECTRIC



Direct Factory Branches:

JACKSONVILLE — 210 W. Eighth St.
TAMPA — 1009 West Platt St.
MIAMI — 704 S.W. 27th Ave.
BIRMINGHAM — 707 21st St., South

Prima Donna

Whatever your "role" in life. and the modern woman fills many, the eyes of the public are turned on you. Husband, employer, children and friends look at you every day. Do you give as much thought as you should to what they see? Some women have so many outside interests that they neglect themselves: others cling to beauty habits formed years ago. Our patrons obtain the maximum results with a minimum of effort through their Luzier Beauty Service . . . Spend an hour with the Luzier Cosmetic Consultant in your community. Plan a Beauty Program just for you. Then you can stand in the spot-light and face your audience with perfect confidence.

Luzier's Fine Cosmetics and Perfumes

Are Distributed in Florida by:

PFEIFER & PFEIFER, DIVISIONAL DISTRIBUTORS

235 North Main Street

Phone: 3-3636, Orlando, Florida

DISTRICT DISTRIBUTORS

MARTHA MATTHEWS
Box 3754
St. Petersburg, Florida
Phone: 75-8242

LOUISE SMITH
1414 E. Central
Orlando, Florida
Phone: 7520

RUBY FATULA
Box 775
Orlando, Florida
Phone: 9898

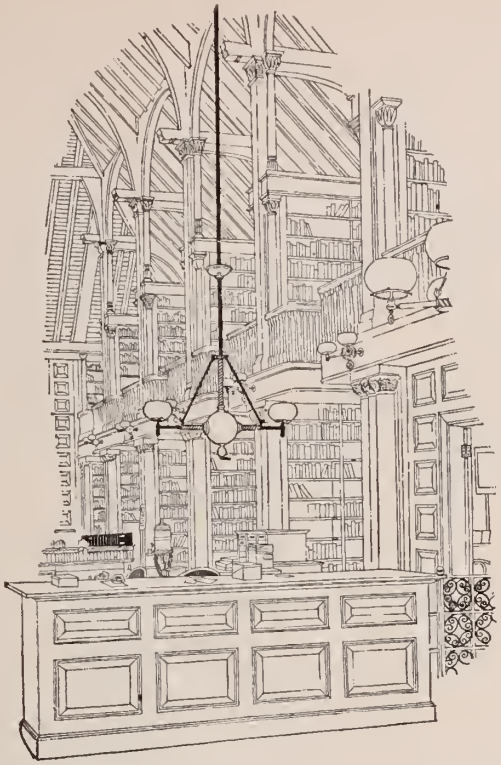
REESE T. VERMILYA
1101 Georgia Ave., Apt. No. 8
West Palm Beach, Florida
Phone: 8069

MAY LUCAS
3404 Cherokee St.
Tampa 9, Florida
Phone: 62-6234

AGNES BRAMLETT
3875 Walsh St.
Jacksonville, Florida
Phone: 2-1575

GERTRUDE SWANGO
Route 4, Box 5-K
Ocala, Florida
Phone: 861 Red

New aureomycin minimal dosage for adults—four 250 mg. capsules daily, with milk.



Interior of the
Howard Memorial Library,
New Orleans, La.

From among all antibiotics Otolaryngologists often choose

AUREOMYCIN

Hydrochloride Crystalline

because

Aureomycin appears rapidly in the tissues of the ear, nose and accessory sinuses, and in the cerebrospinal fluid.

Aureomycin, when given intravenously, attains maximum concentrations in the plasma within 5 minutes.

Aureomycin exhibits little tendency to favor the development of bacterial resistance.

Aureomycin has been reported to be effective against susceptible organisms in the following conditions frequently seen by otolaryngologists:

Laryngeal Infections • Otitis Externa • Otitis Media
Mastoiditis • Pharyngitis • Sinusitis • Tonsillitis

Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

LEDERLE LABORATORIES DIVISION AMERICAN CYANAMID COMPANY 30 Rockefeller Plaza, New York 20, N. Y.

"WOW! Look what the—

MEDICAL SUPPLY MAN just brought!"

No reason to be surprised, fellows. Medical Supply Company carries more than 15,000 individual items in stock at all times. So it's no wonder you see something once in awhile you didn't know we . . . hey, wait a minute . . . you didn't think we meant the *nurse!* We were speaking of the whatever-it-is she's carrying, of course.

Seriously, though, you might well be amazed at the variety of items we keep. In fact, we'll go a step further and say that if you need supplies of any sort, kind or description, we can get them to you in a hurry! In addition, we can actually handle your inventory problems in a way that will cut down the space you need for storage and reduce your working capital, too!

There's no doubt about it! When you need supplies, equipment or repair service, it's a good idea to CALL THE MEDICAL SUPPLY MAN!

HOSPITAL, PHYSICIANS and LABORATORY SUPPLIES & EQUIPMENT

MEDICAL SUPPLY COMPANY

Essentials For Scientific Progress

MIAMI • of JACKSONVILLE • ORLANDO

230 N. E. THIRD ST.
MIAMI 32, FLA.

420 WEST MONROE ST.
JACKSONVILLE 2, FLA.

329 N. ORANGE AVE.
ORLANDO, FLA.

Doctor Harris presents his paper

Among the many demands upon his time and energy are the frequent hospital and medical society meetings which Dr. Harris attends. He never has quite enough time left over for himself. If his prescriptions were less efficient, however, the time he would be forced to spend with each patient would be greater and satisfactory results fewer. To provide more efficient therapeutic agents, the knowledge and special skills of a vast multitude of widely separated research workers are assembled by the pharmaceutical industry. An interesting example of this integration involved . . .

Lilly

. . . ferrets, eggs, and flu

The ferret's ability to drive his prey out of hiding gave his name a special significance when he was used in the laboratory to "ferret out" the elusive influenza virus. From throat washings of influenza patients, investigators recovered a virus pathogenic for ferrets and then demonstrated that antibodies against the virus were produced during convalescence. Other research groups found that the causative strains varied from one epidemic to another. Still others devised a method for removing the virus from the allantoic fluid of inoculated embryonated eggs to provide a practical means of producing ample vaccine. Finally, clinicians, including those with Eli Lilly and Company, were able to establish the preventive value of this material. The problem of varying epidemic strains, however, called for large but flexible production. Eli Lilly and Company shared in a successful trial-run which indicates that the pharmaceutical industry is able to cope with nationwide influenza epidemics in a matter of weeks. Such co-operative undertakings, financed by industry, join the talents of many investigators, lending to their efforts the important purpose of giving man increased freedom from disease.

Lilly ELI LILLY AND COMPANY · INDIANAPOLIS 6, INDIANA, U. S. A.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXIX | Jacksonville, Florida, July, 1952 | No. 1

Further Observations on a New Concept of Baby Feeding

WALTER W. SACKETT, JR., M.D.
AND
BEN J. SHEPPARD, M.D.
MIAMI

The purpose of this paper is to present our further observations and findings on the continued application of "A New Concept of Baby Feeding." The first paper on this subject appeared in the August 1951 issue of The Journal of the Florida Medical Association following its presentation at a scientific meeting of the Florida Academy of General Practice. The substance of this original article is outlined in the presentation of an actual baby feeding schedule as used in our office practice (table 1).

During the year that has ensued we have continued to proceed with the further investigation of the merits of a concept embodying this six hour feeding interval with an early introduction of food. The main intent of this paper is to report on the clinical aspects of such a regimen as observed in our office practice, and also to report on the degree of acceptance and success of this concept as manifested by parent reaction to a number of questions.

A sincere effort has been made to follow weights as well as blood levels by recording both these findings on the occasion of routine office visits and at the time of special visits.

Minor changes in feeding details and closer study of records have been instrumental in modifying early impressions of trends in weight. The initial loss of weight would not seem to be as great as it was in our experience with other feeding routines, and not infrequently in an average size baby the initial loss of 4 to 6 ounces is erased by the time the baby leaves the hospital on the fourth or fifth day. For the next three to four weeks the gain in weight would seem to lag behind that to be expected at this stage of life, but thereafter the increase quickly erases this early deficit. Whereas this temporary retardation in weight increment was at one time a source of deep concern to weight-conscious parents, this concern is avoided by stressing other desired attributes resulting from this regimen.

As a matter of didactic interest, we point to one baby with a weight at birth of 4 pounds, 12 ounces who was able to follow the concept closely both as to feeding intervals and as to the addition of foods. The lowest weight encountered in any baby was in one weighing just a bit over 5 pounds at birth whose weight dropped to 4 pounds, 8 ounces before entering the phase of primary increase. It is not our purpose here to infer that this concept is applicable to premature infants; on the contrary, it was our belief that the babies mentioned were full term but small babies.

In charting blood levels we find these babies exhibit a tendency to follow closely the pattern of control babies as observed in our office practice, the controls being comprised of babies on the more conventional four hour schedule. Up until the fourth week of life they maintain a concentration of hemoglobin around 100 per cent (17.0 Gm.). This gradually drops off to a 55 to 65 per cent level at five to six months and then seems

Table 1.—Six-Hour Feeding Schedule

Feedings at 6 a.m., 12 noon, 6 p.m. and 12 midnight
Water between feedings
At 3 to 4 days old: Cereal at 6 a.m. and 6 p.m.
At 10 days old: Strained vegetables at 12 noon
(Peas, beans and carrots suggested as starters)
At 17 days old: Strained fruits at 6 p.m.
(Applesauce, peaches and pears suggested as starters)
May decrease cereal.
At 2 weeks old: Concentrated cod liver oil,
2 drops a day to start; increase 1 drop a month up to 5 drops daily.
At weekly intervals add:
3 weeks: Orange juice and sterile water, equal parts of each, up to 2 ounces of each at 6 a.m.
4 weeks: Strained meats
5 weeks: Custards
6 weeks: Soups
7 weeks: Mashed banana
8 weeks: Hard-boiled egg yolk

Read before the Florida Academy of General Practice, Second Annual Scientific Meeting, Ocala, Oct. 14, 1951.
From the Medical Research Unit, University of Miami, Coral Gables.

to rise slowly to a 65 to 75 per cent level, which to us is average for the children and babies in this subtropical region. Unfortunately, there have been no norms established for this subtropical climate, so that any isolated work suffers from the lack of a standard of comparison. It is our further observation that normal babies manifest these trends whether or not they are on hematinic therapy.

Questionnaire

In order to ascertain further the degree of patient acceptance and reaction to this new concept, a questionnaire (table 2) was returned by 123 mothers whose babies are being reared on this six hour accelerated schedule. Each questionnaire was accompanied by a letter appealing for unbiased answers to the individual questions.

In reply to question 1, 61 per cent of this group reported having followed the six hour schedule closely and 32 per cent moderately well. Three per cent followed it poorly and 4 per cent not at all. A more complete and universal acceptance of this prolonged feeding interval has been decidedly tempered by prejudice against any such revolutionary variation from procedures which have been standard for years. In contrast to this modified acceptance of a six hour interval on the part of the private patient stands its unquestioned, unanimous acceptance and proof of workability as proclaimed by nurses staffing a newborn nursery and by the attending personnel in an institution keeping a varying census of infants ranging from newborn to one year.

Question 2 revealed a phase of this new concept which has received practically unanimous approval from mothers. Ninety-three per cent reported following the early addition of foods closely (see feeding schedule, table 1, for details), while 6 per cent reported following their early addition moderately well. Less than 1 per cent reported following this phase poorly. These results would seem to substantiate from a practical standpoint previous scientific findings to the effect that babies can early and advantageously tolerate foods other than milk in the neonatal period and early weeks of life.

The answers to question 3 would seem to indicate little except that there is a wide latitude permitted by mothers when considering the problem of limiting their babies to a three meal routine. While the majority of mothers, namely 67 per cent, dropped the midnight feeding by seven weeks, a small per cent, 3 per cent, gave no midnight feeding at all, thus having their babies on a three meal a day schedule from birth. About 26 per cent of mothers had dropped this midnight feeding by three weeks, while a few did not drop it until the twentieth to twenty-first week.

Question 4 included a number of subquestions:

1. Fifty-two per cent of the mothers indicated that their babies sat unsupported before the age of six months; 86 per cent of the babies sat unsupported before the seventh month period.

2. Seventy-five per cent reported that their babies were able to stand unsupported within the first nine month period.

3. Sixty per cent reported that their babies walked unsupported in the ninth, tenth and eleventh month period.

4. Ninety-five per cent reported the appearance of the first tooth in the third to eighth month period, while the greatest number were reported in the sixth month.

Question 5 also included a number of subquestions:

1. Ninety-four per cent of the mothers reported that their babies took new foods more readily; 5 per cent reported in the negative with 1 per cent reporting "don't know."

2. Eighty-one per cent reported that their babies had fewer bowel upsets with 14 per cent answering in the negative and 5 per cent "don't know."

3. Seventy-eight per cent reported that their babies had fewer allergic manifestations with 15 per cent answering in the negative and 7 per cent "don't know." While this apparently great increase in the negative answer to this question might seem to indicate an argument against this feeding concept, we are more willing to believe that it results from an increasing awareness on the part of the modern parent as to what constitutes an allergic manifestation. With the newer ideas on food allergies as expressed by Rinkel, we would be inclined to reason that fewer food allergies would be produced by this method of feeding in which there is an early and pronounced rotation of foods rather than a continued feeding of a single food substance for a longer period of time.

4. Eighty-seven per cent indicated that the baby in question was a more contented baby than previous babies or those of friends or neighbors, and 12 per cent answered in the negative with 1 per cent replying "don't know."

5. Eighty-nine per cent indicated that the baby learned to amuse himself more readily, while 7 per cent answered in the negative and 4 per cent replied "don't know."

In answering question 6, 94 per cent believed that the baby in question permitted more rest and ease of mind than other siblings or babies of friends, neighbors or relatives, while 5 per cent answered in the negative, with 1 per cent replying "don't know."

Replying to question 7, 92 per cent reported that they were completely satisfied with the baby's progress, both physical and mental, on this schedule, while 7 per cent gave negative responses and 1 per cent gave a noncommittal response.

While it might be argued that all the preceding questions are based on different points of theory in this concept, question 8 pertains to the application or practicability of this concept, namely, "If you had another baby, would you rear it on this six hour schedule?" Ninety-two per cent answered in the affirmative, a response which to us is especially gratifying. Three per cent answered in the negative, and 5 per cent answered "don't know." Several of the mothers, all primiparas, explained their seemingly unfavorable answers by expressing a desire to try a future baby on one of the more standard types of feeding in order to have a basis for comparison. Unfortunately, there is no way of reporting in this paper the numerous emphatic little comments which were added to the affirmative answers. Likewise, to keep the report on the honest side, we should not fail to mention the two mothers who were equally emphatic in comments on the negative side. And to

Table 2.—Questionnaire Concerning Your Results with the New Six-Hour Accelerated Feeding Program

1. Did you adhere to the 6-hour schedule? (Check one)	Closely ☐ Moderately well ☐ Poorly ☐ Not at all ☐
2. Did you adhere to the early addition of foods? (Check one)	Closely ☐ Moderately well ☐ Poorly ☐ Not at all ☐
3. At what age did you drop the midnight feeding and place your baby on a three meal a day schedule?	.....weeks
4. At what age did your baby — sit unsupported?	.....months
— stand unsupported?	.....months
— walk unsupported?	.....months
— have its first tooth?	.....months
5. In comparison with your previous babies or with those of your friends or neighbors, do you believe that this baby — took new foods more readily?	Yes ☐ No ☐
— had fewer bowel upsets?	Yes ☐ No ☐
— had fewer allergic manifestations?	Yes ☐ No ☐
— was a more contented baby?	Yes ☐ No ☐
— learned to amuse himself readily?	Yes ☐ No ☐
6. Do you think that this baby permitted you more rest and ease of mind than your other babies or those of your friends, neighbors or relatives?	Yes ☐ No ☐
7. Were you completely satisfied with your baby's progress, both physical and mental, on this schedule?	Yes ☐ No ☐
8. If you have another baby, would you rear it on this 6-hour accelerated schedule?	Yes ☐ No ☐

Please give here any comments or further information regarding your baby (blood counts, if any, serious illnesses and suggestions):

(Continue on back of this sheet)

Parent's Name.....

Baby's Name.....

Mailing Address.....

.....

Sincerely,

Walter W. Sackett, Jr., M.D.
Ben Sheppard, M.D.
Research Associates, Medical
Research Unit, University of Miami

be scrupulously honest, one of the mothers giving a negative reply admitted in a postscript that had her husband filled out the questionnaire, he would definitely have been for the program. Her negative answers to these questions were based on her inability to nurse her baby, which she attributed to the six hour interval. We believe that her thoughts regarding breast feeding were erroneous, as will be explained in a subsequent paragraph. Even though this report fails to encompass much more than one and a half to two years of trial, one mother who subsequently moved to Illinois emphasized her favorable answers to these questions by stating that she is rearing a second baby on this schedule despite the fact that the baby is under the care of another physician in a distant state.

The question as to the adaptability of breast feeding to this program often arises. During World War II one of us often was asked if a working mother could nurse her baby morning and evening and leave a noonday bottle for her baby. It was found that this arrangement would work admirably, thus permitting an interval of between eight and 12 hours between breast feedings. This principle of natural adaptation of the flow of milk to the demand for milk works equally as well with nursing mothers on the six hour schedule. Furthermore, the long night interval, whether the baby is on a six hour or four hour schedule, would tend to prove that mothers could go for equally as long intervals during the day.

It has been reported to us by physicians in various parts of the country that they have had only fair results with this schedule. We should like to state that there are countless numbers of circumstances which mitigate against the acceptance of this concept of baby feeding. They would include the wide publicity by lay publications given to the demand type of feeding plus the willingness on the part of neighbors, grandmothers and friends to explain any upsets on the part of the baby on the basis of whatever feeding regimen is being carried out. One of us, engaged in general practice, makes a sincere effort to indoctrinate his obstetric patients along the lines he has in mind during the pregnancy. Considerable time is taken upon discharge from the hospital to explain this schedule thoroughly to the mother and to encourage her to start on this schedule. It is our opinion that, were we able to spend additional time with the mothers when they are faced with minor problems at home, we could increase substantially the number of mothers who would accept this six hour schedule.

On numerous occasions we have been accused of omitting from this schedule a most important element in the emotional development of a baby, namely, parental love. On the contrary, we urge parents to manifest an ample supply of this emotion by loving, cuddling, playing with and even rocking the infant at frequent intervals, but only when the baby is awake and not crying, rather than when he is crying. Indeed, it is the admonition of one of us that he would prefer to awaken the baby from a sound sleep for the display of such an emotion rather than to demonstrate it during a crying episode on the part of the baby.

In conclusion, it is our opinion from a medical standpoint as based on accurate records and clinical observations of these babies that in health, development, both mental and physical, and general well-being they are on a par with those babies brought up on the more generally accepted theories of baby feeding. We believe, however, that the main advantage in this schedule lies in the contribution to the mother's stability, which in turn is reflected in a baby who will present fewer feeding problems during the ensuing years of life. In addition to there being a better level of adjustment between the mother and the baby, the application of this concept of feeding permits a mother to devote more time to the remaining family obligations. As these babies progress into a more advanced state of childhood, impressions continue to mount to the effect that babies reared on a schedule such as embodied in this new concept are a happy and contented lot, in direct contrast to those babies subjected to a demand schedule, who seem to develop constantly along "demanding lines." Our observations would tend to serve as a direct refutation to the thoughts of the modern child psychologist, who might be tempted to label babies fed on a six hour schedule as "thwarted individuals" with an assured impaired psychiatric outlook on life.

Summary

A trial of almost two years of a new concept of baby feeding, involving an initial six hour feeding interval for babies from birth with an early introduction of foods, would tend to prove by the accepted criteria a degree of workability and acceptance far beyond expectations anticipated at its inception. These favorable results apply not only to the baby but to the mother as well.

Acknowledgment is made of a quantity of homogenized foods made available for this program by Lilly, McNeill & Libby of Chicago.

References

Blatt, M. L.; Jacobs, H. M.; Murphey, J. B., and Zeldes, Mary: The Addition of Homogenized Vegetables to the Diet of the Young Infant. From St. Vincent's Infant and Maternity Hospital, Chicago.
Caldwell, G. W.: Value of Homogenized Foods in Infant Feeding, J. Am. Dietet. A. 11:428-436 (Jan.) 1936.
Clein, N. W.: Cow's Milk Allergy in Infants, Ann. Allergy 9:195-204 (March-April) 1951.
Libby, McNeill & Libby: Solid Foods for Infants, Chicago, 1937.
Rinkel, Herbert J., and others: Food Allergy, Springfield, Ill., Charles C. Thomas, 1951.
Sackett, W. W., Jr.: New Concept of Baby Feeding, J. Florida M. A. 38:109-112 (Aug.) 1951.

2500 Coral Way.

Prolapse of the Gastric Mucosa into the Duodenum: Report of Eight Cases

Sidney Stillman, M.D.
Jacksonville

Prolapse of the gastric mucosa into the duodenum, though once considered rare, has been diagnosed frequently in the past few years. The syndrome was originally described by Schmieden[1] in 1911. It was not recognized in this country until 1925 when Eliason and Wright[2] presented a case. A review of the literature up to the present time reveals that over 100 cases have been diagnosed roentgenologically and at least 44 cases have been proved by surgery. The following is a list of a few of the reported cases in addition to those mentioned: Eliason, Pendergass and Wright,[3] 2 cases in 1926; Meyer and Singer,[4] 1 case in 1931; Shiflett,[5] 1 case in 1932; Meyer,[6] 1 case in 1935; Pendergass and Andrews,[7] 3 cases in 1935; Rees,[8] 4 cases in 1937; Bohrer and Copleman,[9] 1 case in 1938; Archer and Cooper, [10] 4 cases in 1939; Rubin,[11] 1 case in 1942; Melamed and Hiller,[12] 1 case in 1943; Norgore and Shuler,[13] 1 case in 1945; MacKenzie, Macleod and Bouchard,[14] 2 cases in 1946; Scott,[15] 14 cases in 1946; Appleby,[16] 6 cases in 1947; Judd and Moe,[17] 1 case in 1947; Nygaard and Lewitan,[18] 1 case in 1948; DiLeo, Kuker and Shepard,[19] 1 case in 1948; Manning and Highsmith,[20] 16 cases in 1948; Ellison and Squire,[21] 5 cases in 1949; Cove and Curphrey,[22] 22 cases in 1949; and Kaplan and Shepard, [23] 3 cases in 1951. During a period of five years, I have observed 8 cases which have been diagnosed roentgenologicaly. Surgical confirmation was not obtained, as in no case were the symptoms severe enough to warrant exploration.

Etiology

The etiology of the condition is not definitely known, but several theories have been propounded. Eliason and Wright[2] postulated that chronic irritation of the gastric mucosa due to physical, nutritional, chemical, functional, or bacterial causes might result in chronic inflammation and hypertrophy. The latter are further increased by peristalsis of the stomach and gastric contents. Golden[24] and Forssell[25] studied the gastric mucous membrane. Golden's studies of antral systole threw further light on the possible etiology of the condition by his observation that in some cases the mucosal folds run transversely to the long axis of the stomach, and during antral systole these assume a longitudinal course and may move cephalad. Should this cephalad movement fail to occur in antral systole, the mucosa is forced by pressure through the pyloric canal. Rees[8] proposed that there is first a narrowing of the pylorus, and this is followed by hyperperistalsis in an effort to force the contents through the narrow opening. The attachment of the mucosa to the muscularis becomes loosened and subject to trauma, resulting in hypertrophy and prolapse. MacKenzie, Macleod and Bouchard[14] did not support any of these theories, but were of the opinion that emotional factors precipitate the condition. Scott[15] considered the conditions necessary for prolapse to be inherent in the normal stomach, with prolapse only occuring after the flexible fibers of the submucosa have become stretched and loosened by abnormal peristalsis. This, in time, is initiated by neurogenic or chemical stimuli or a combination of both. Manning and Highsmith[20] emphasized the importance of chronic hypertrophic gastritis from any cause involving the antral mucosa. The interference with the normal mechanism of antral systole will result

in the development of prolapsing redundant mucosa in a majority of the cases.

Symptoms

There is no symptom complex characteristic of the disease, and it is rarely diagnosed before roentgen study. The symptoms include intermittent epigastric distress, fulness, gaseous distension, nausea and vomiting. Obstructive symptoms with distress after eating were noted by Rees.[8] In several cases reported in the literature gross hematemesis occurred. Pendergass and his associates[3,26] stressed the incidence of secondary anemia of a severe grade due to ulceration and oozing. The discomfort lacks the periodicity of peptic ulcer. Eliason and Squire[21] were impressed by the cramplike distress in the epigastrium of varying severity and generally worse under nervous tension. One should suspect the condition in any atypical history of ulcer.

Incidence

The condition is apparently most common in the fourth and fifth decades. A review of 44 cases in which the patient was operated upon revealed 28 males and 16 females. Except for peptic ulcer and gastritis, gastric mucosal prolapse is the most important of the benign conditions affecting the distal end of the stomach and the duodenal bulb.

Pathology

Manning and Gunter[27] were able to study the gross and microscopic pathologic manifestations in 6 cases. In 5, there was mild to severe gastritis. Grossly and microscopically, the gastritis appeared to be of the hypertrophic type except in 1 case in which atrophic changes predominated. In 4 cases the submucosa was unusually loose so that it appeared as a tonguelike polypoid fold protruding through the pylorus.

In 1 case the prolapsed mucosa was a hypertrophied fold which was forced caudally into the duodenum by the hypertrophied pyloric muscle. The pyloric muscle was thickened, and the pyloric channel appeared narrowed in 4 cases. The muscularis mucosae was thickened in 3 cases and showed myelocystic infiltration in 1 case. The prolapse may be unilateral or circular and complete. In the unilateral type a portion of the prepyloric gastric mucosa slips into or through the pyloric canal presenting itself on one side of the base of the duodenal bulb projecting into the lumen. The pyloric sphincter contracts on the mass, the end of which becomes swollen and engorged while the portion in the canal is stretched out. In the circular type there is complete separation of the prepyloric mucosa from its muscularis. The mucosa slides through the pylorus in the form of a cylinder propelled by peristalsis and may remain fixed there in a manner similar to a small intestinal intussusception. The cylinder of tissue presents in the base of the bulb of the duodenum, and a central depression marks the pyloric canal. Studies of the gastric analysis for acidity were not consistent. Gastric acidity from 0 degrees free and 13 degrees total to 75 degrees free and 90 degrees total has been reported.

Roentgen Diagnosis

The roentgenologic appearance of this condition was described vividly by Eliason, Pendergass and Wright.[3] They described a central, circular, or irregular circular filling defect in the duodenum, usually at the base of the duodenal bulb, with elongation and narrowing of the pyloric channel. The extent of the defect is governed by the amount of prolapsed mucosa. One rarely discovers it in the erect position — most often in the horizontal and right oblique position. A six hour residue is frequent. The stomach may appear normal, but usually long mucosal folds are found in the antrum associated with antral spasm. In many cases Manning and Highsmith[20] reported a rather constant "umbrella" or "mushroom" deformity in the base of the duodenal cap as the most characteristic roentgenologic finding with or without elongation and narrowing of the pyloric channel and increase in the size of the rugae of the pylorus and antrum. This condition has to be differentiated from pyloric ulcer, hypertrophic gastritis, prolapsing gastric polyps, duodenal polyps and carcinoma of the stomach. A definite diagnosis can only be made by exploratory laparotomy.

Treatment

In all cases of prolapsed gastric mucosa the patient should be given the benefit of medical treatment initially. The medical regimen recommended is a bland diet, antiacids, antispasmodics and mild sedation. One should endeavor to have the patient avoid emotional tension and all contributing factors such as smoking, alcohol, chronic respiratory infections and dental caries. In a majority of cases it is a reversible state, and surgery is not indicated. If no improvement is ascertained in a month's rigid medical treatment, surgery should be contemplated. Several operations are

suggested and performed. The operations generally used include excision of the redundant mucosa and pyloroplasty, gastric resection, gastroenterostomy, simple excision of redundant mucosa, excision of the mucosa and gastroenterostomy, pyloroplasty and closure of the pylorus and gastroenterostomy. Kaplan and Shepard[23] reported 4 surgical cases. In 1 a Heineke-Mikulicz pyloroplasty was performed, in 2 excision of redundant mucosa and a Heineke-Mikulicz pyloroplasty, and in the fourth a simple excision of redundant mucosa. The results were good in the first type of surgery. In the second type the results were excellent in 1 case, and in the other the patient died of complications. In the fourth case a gastroenterostomy was necessary at a later date.

Report of Cases

Case 1. — H. S., a white man aged 44, complained in June 1948 of epigastric distress for the past six months. The pain was "aching" in character, lasted ten to fifteen minutes, usually appeared two hours after eating, and was relieved by eating or belching. He vomited occasionally, but no blood was in the vomitus. Physical examination and blood studies gave essentially negative results. Roentgen examination revealed a constant deformity of the antral portion of the stomach with a constant niche. The patient was treated with antispasmodics, diet and sedatives. When roentgen examination was repeated in July, there was evidence of widening of the pyloric canal, which was attributed to hypertrophy of the sphincter, as well as thickening of the mucosa with slight prolapse into the duodenal bulb (fig. 1). The constant niche had disappeared. The last roentgenograms, in January 1950, showed some widening of the pyloric channel still present, but considerable improvement of the prolapse. The patient is comfortable as long as he continues the ulcer regimen.

Figure 1

Case 2. — A. Z., a white man aged 43, in December 1948 gave a history of having eaten some highly seasoned salad the day before, and as a result he had severe "heartburn." He had taken an effervescent alkalinizing analgesic preparation which had relieved the condition to a slight extent. Physical examination was essentially negative except for moderate hypertension. Laboratory tests were noncontributory. Roentgenograms of the stomach revealed heavy rugae formation in the antrum of the stomach, and the duodenal cap showed a typical mushroom type of filling found in a prolapse of the mucosa through the pylorus (fig. 2). The patient was treated with antiacids, antispasmodics, sedatives and a bland diet. He was symptom-free as long as he continued this regimen. Roentgenograms in January 1951 still showed a normal duodenal cap except for indentation at the base, attributed to pressure from the pyloric muscle and possibly a slight degree of prolapse of the haustral mucosa.

Figure 2

Case 3. — J. G., a white man aged 43, related on Sept. 19, 1949, that on several occasions in the past three months he had been awakened from a deep slumber with a feeling of fulness and giddiness in the stomach. He found belching or vomiting would give him relief. There was no relation to types of foods nor to time of eating. Physical examination revealed tenderness in the epigastric area. Laboratory examinations, including a complete blood count,, urinalysis, sedimentation rate, fasting sugar, and stools gave negative results. Roentgenograms of the stomach showed heavy rugae formation in the antral portion, but no constant filling defect. At times a definite mushroom type of filling was seen in the duodenal cap (fig 3). On an ulcer regimen the patient showed some improvement, but continued to have occasional attacks of a similar nature and refused to consider surgery.

Case 4. — B. W. C., a white man aged 58, in April 1950 gave a lengthy history of "stomach" distress, relating that he had been subjected to roentgen examination at least twice a year for the past five years. His complaints consisted of slight pain in the epigastric region and bloating, which were aggravated by tension. He had tried every kind of ulcer regimen with little relief, and concluded that sedatives gave him maximum relief. Physical examination gave negative results except for slight tenderness along the descending colon. An alkaline tide test revealed excessive acidity. Electrocardiographic and other laboratory tests were not significant. Roentgenograms taken at this time showed the antral rugae to be exceptionally heavy and some mushrooming into the duodenal cap due to prolapse of the gastric mucosa through the pylorus (fig. 4). The patient was instructed concerning his condition and again given a bland diet, antiacids, antispasmodics and sedatives.. On this occasion he was relieved to a great extent, the reason for which I cannot explain. Roentgenograms of the gastrointestinal tract were again taken in February 1951, and the same condition was apparent.

Figure 3

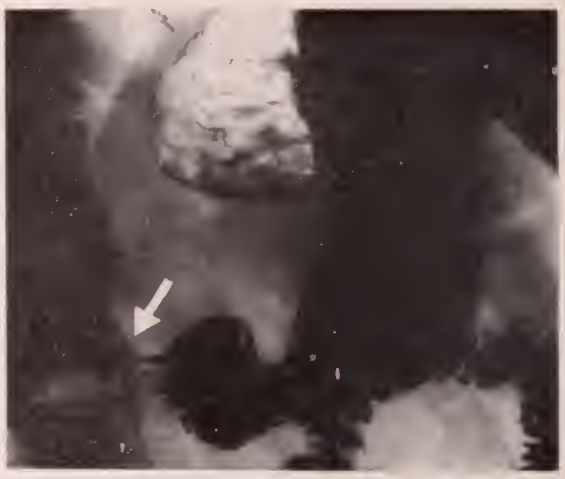


Figure 4

Case 5. — E. L., a white woman aged 40, stated in February 1951 that she had been having severe "indigestion." For the past three months she had observed that the consuming of food or belching would alleviate the discomfort. Fried and highly seasoned foods would aggravate the symptoms. Physical examination revealed slight tenderness in the epigastric area. No masses could be felt. Laboratory examinations gave negative results, but roentgenograms of the upper part of the gastrointestinal tract showed a prolapse of the gastric mucosa through the duodenal cap, giving a mushroom type filling (fig. 5). This patient responded significantly to an ulcer regimen.

Case 6.—H. D., a white man aged 23, in March 1951 complained of "hurting in the pit of the stomach" and stated that he had been awakened from a profound sleep with this discomfort. He would often vomit bile-tinged material and was continually belching. He had been under a great deal of stress of late precipitated by his second matrimonial venture. Physical examination gave essentially negative results. Gastric analysis with 7 per cent alcohol gave a maximum acidity of free 35 degrees, total 55 degrees. Other studies were noncontributory. Roentgenograms of the upper part of the gastrointestinal tract revealed some spasticity in the antral portion of the stomach and evidence of prolapse of the gastric mucosa into the duodenal cap (fig. 6). The patient has had alleviation of distress since he has adhered to a bland diet, antispasmodics and antiacids.

Case 7. — E. C. I., a white man aged 56, on his initial visit gave a lengthy history of "heartburn." The discomfort would awaken him at night, and he believed that food aggravated the condition. He was taking milk of magnesia tablets excessively with slight relief. Physical examination revealed tenderness of considerable degree in the epigastric area as well as over the gallbladder. Laboratory observations were noncontributory. Roentgenograms of the intestinal tract showed that the antral rugae were somewhat heavy with slight indentation into the duodenal cap, characteristic of early prolapse of the gastric mucosa into the duodenal cap (fig. 7). The symptoms were slightly improved on an ulcer regimen.

Case 8.—I. E., a white man aged 39, was seen initially in May 1948, at which time he gave a history of "stomach" trouble for the past ten years. When the discomfort first started he would get dull pains in the "pit" of the stomach, especially during periods of emotional stress. He was immediately relieved with dieting and antiacids. While in service in 1944, he had a gastric hemorrhage. All procedures including roentgenograms gave negative results. At the time of his discharge from the Army in 1946, roentgen examination was again repeated, but gave no evidence of pathologic change.

Figure 5

Figure 6

Physical examination on the initial visit gave negative results. A gastric analysis with 7 per cent alcohol gave a maximum acidity of free 42 degrees, total 75 degrees. The results of other laboratory procedures were essentially negative, and roentgen examination of the gastrointestinal tract also gave negative results.

In August 1951, the patient reported having had severe nausea for several days. While at the theater he became weak and on arriving home evacuated "tarry stools." He was hospitalized, and on examination the stools exhibited definite evidence of blood. The hemoglobin estimation was 72 per cent, whereas on all previous occasions it had been in the nineties. Treatment consisted of absolute bed rest and the Sippy routine. After several days a roentgenogram of the upper part of the gastrointestinal tract was ordered. The roentgenologist on this occasion reported that the distal portion of the antrum showed evidence of mucosal hypertrophy with invagination into the base of the duodenal bulb (fig. 8). The patient responded excellently to ulcer regimen and hematinics.

Summary

Eight cases are reported in which the clinical and roentgenologic findings were consistent with a diagnosis of prolapse of the gastric mucosa through the duodenum.

The condition is not a rarity if one bears it in mind.

One finds it more prevalent in the older age group and principally in males.

No definite conclusion can be made as to the specific etiology.

Figure 7

In all cases the patient should have the benefit of a medical regimen, and if relief is not obtained, one should consider surgery.

When surgery is definitely indicated, excision of the redundant mucosa with pyloroplasty is recommended.

The roentgenograms were made available through the courtesy of Drs. H. Bernard McEuen, Floyd K. Hurt and Wade S. Rizk.

References

1. Schmieden, V.: Die Differentialdiagnose zwischen Magengeschwür und Magenkrebs: die pathologische Anatomie dieser Erkrankungen in Beziehung zu ihrer Darstellung im Röntgenbilde, Arch. f. klin. Chir. 96:253-344, 1911.
2. Eliason, E. L., and Wright, V. W. M.: Benign Tumors of Stomach, Surg. Gynec. & Obst. 41:461-472 (Oct.) 1925.
3. Eliason, E. L.; Pendergass, E. P., and Wright, V. W. M.: Roentgen-Ray Diagnosis of Pedunculated Growths and Gastric Mucosa Prolapsing Through Pylorus, Am. J. Roentgenol. 15:295-322 (April) 1926.
4. Meyer, K. A., and Singer, H. A.: Intermittent Gastric Ileus Due to Mechanical Causes, Surg., Gynec. & Obst. 53:742-749 (Dec.) 1931.
5. Shiflett, E. L.: Tumors of Duodenum and Hypertrophied Gastric Mucosa Prolapsing Through Pyloric Canal into Duodenum; Case Reports, with Review of Literature, Radiology 19:79-90 (Aug.) 1932.
6. Meyer, W. H.: Importance of Roentgen Gastric Functional Study in Differential Diagnosis of Pyloric Lesions, Radiology 24:206-212 (Feb.) 1935.
7. Pendergass, E. P., and Andrews, J. R.: Prolapsing Lesions of Gastric Mucosa, Am. J. Roentgenol. 34:337-350 (Sept.) 1935.
8. Rees, C. E.: Prolapse of Gastric Mucosa Through Pylorus, Surgical Treatment, Surg. Gynec. & Obst. 64:689-694 (March) 1937.

Figure 8

9. Bohrer, J. V., and Copleman, B.: Prolapsing Redundant Gastric Mucosa; Case Report, Radiology 31:220-222 (Aug.) 1938.
10. Archer, V. W., and Cooper, G., Jr.: Prolapse of Gastric Mucosa, South. M. J. 32:252-256 (March) 1939.
11. Rubin, J. S.: Prolapse of Polypoid Gastric Mucosa into Duodenum, with Malignant Change, Radiology 38:362-364 (March) 1942.
12. Melamed, A., and Hiller, R. I.: Prolapsed Gastric Mucosa; Roentgenologic Demonstration of Ulcer Crater in Prolapsed Polypoid Mucosa, Am. J. Digest. Dis. 10:93-95 (March) 1943.
13. Norgore, M., and Shuler, I. J. D.: Extrusion of Gastric Mucosa Through Pylorus; Report on Two Patients Treated by Partial Gastrectomy, Surgery 18:452-457 (Oct.) 1945.
14. MacKenzie, W. C.; Macleod, J. W., and Bouchard, J. L.: Trans-pyloric Prolapse of Redundant Mucosal Folds, Canad. M. A. J. 54:553-558 (June) 1946.
15. Scott, W. G.: Radiographic Diagnosis of Prolapsed Redundant Gastric Mucosa into Duodenum, with Remarks on Clinical Significance and Treatment, Radiology 46:547-568 (June) 1946.
16. Appleby, L. H.: Prolapsing Gastric Mucosa, J. Internat. Coll. Surgeons 10:135-141 (Mar.-Apr.) 1947.
17. Judd, E. S., Jr., and Moe, A. E.: Chronic Hypertrophic Gastritis Complicated by Obstruction; Report of Case, Proc. Staff. Meet., Mayo Clin. 22:241-245 (June 11) 1947.
18. Nygaard, K. K., and Lewitan, A.: Transpyloric Herniation of Redundant Gastric Mucosa, Am. J. Surg. 75:502-515 (March) 1948.
19. DiLeo, J. F.; Kuker, L. H., and Shepard, R. M.: Prolapse of Gastric Mucosa into the Duodenum, Case Report and Analysis of Reported Cases, New Orleans M. & S. J. 101:-428-435 (Mar.) 1949.
20. Manning, I. H., Jr., and Highsmith, G. P.: Prolapse of Gastric Mucosa Through Pyloric Canal into Duodenum; Report of Sixteen Cases Diagnosed Roentgenologically, Gastroenterology 10:643-659 (April) 1948.
21. Ellison, A. B. C., and Squire, E. W.: Prolapse of Gastric Mucosa into Duodenum, West Virginia M. J. 49:237-239 (Sept.) 1949.
22. Cove, A. M., and Curphrey, W. C.: Prolapse of Redundant Gastric Mucosa, Surg., Gynec. & Obst. 88:108-114 (Jan.) 1949.
23. Kaplan, I. W., and Shepard, R. M.: Prolapse of Gastric Mucosa into Duodenum, J. A. M. A. 147:554-560 (Oct. 6) 1951.
24. Golden, R.: Antral Gastritis and Spasm, J. A. M. A. 109:-1497-1500 (Nov. 6) 1937.
25. Forssell, G.: Mechanism of Movement of Mucous Membrane of Digestive Tract, Am. J. Roentgenol. 10:87-104 (Feb.) 1923.

26. Pendergass, E. P.: Prolapse of Pedunculated Tumors and Gastric Mucosa Through Pylorus into Duodenum, J. A. M. A. 94:317-321 (Feb. 1) 1930.

27. Manning, I. H., Jr., and Gunter, J. U.: Prolapse of Redundant Gastric Mucosa Through Pylorie Canal into Duodenum, Am. J. Path. 26:57-73. (Jan.) 1950.

28. Bralow, S. P., and Melamed, M.: Prolapse of Redundant or Hypertrophied Gastric Mucosa, Am. J. Digest. Dis. 14:215-221 (July) 1947.

29. Zimmer, E. A.: Klinik und Röntgenologie des Prolapses von Magenschleimhaut in den Pylorus und in den Bulbus duodeni, Schweiz. med. Wchnschr 80:351-358 (April 8) 1950; abstracted by Lang, E. F., in Am. J. Roentgenol. 65:649-650 (Apr.) 1951.

217 West Ashley Street.

Incidence of Heart Disease in School Children of Pensacola, Florida

LIEUTENANT JOHN M. PACKARD, MC, USN
LIEUTENANT JOHN S. GRAETTINGER, MC, USN
AND
CAPTAIN ASHTON GRAYBIEL, MC, USN
PENSACOLA

In 1949 a study of the cardiovascular status of school children in Pensacola, Fla., was undertaken by the Naval School of Aviation Medicine in conjunction with the Florida State Board of Health. The purpose of this study was twofold: first, to determine the types and incidence of heart disease in a representative sample of school children residing in Northwest Florida, and second, to establish standards for the electrocardiogram and for heart size in healthy persons 10 to 20 years of age. This report will include a description of materials and methods used in the study and a presentation of the findings in the cases of heart disease. Subsequent reports will present an analysis of the electrocardiographic and roentgenographic findings in the children without heart disease.

Description of Pensacola and Its School System

Pensacola is situated on the Gulf of Mexico near the northwest border of Florida at a latitude of 30 degrees 25 minutes north and a longitude of 87 degrees 13 minutes west. The elevation of the major part of the town is 12 feet above sea level. The annual rainfall over the past 71 years has averaged 59.5 inches. The mean temperature is 67.8 F., varying from a mean temperature in the winter of 54.3 F. to a mean summer temperature of 80.5 F. The population of Pensacola proper in the 1950 census was 43,263. If the surrounding communities are included, the population of greater Pensacola is 76,700. The city is situated in Escambia County, which has a population of 112,756 (ranking ninth in the state) and an area of 608 square miles (ranking thirty-eighth in area).

The public school system for white children in Pensacola is composed of one high school, two junior high schools, and six elementary schools. Three schools were selected for the survey: the high school, which serves the surrounding communities as well as the city proper; the larger of the two junior high schools, which draws its students from within the city limits from a slightly lower socioeconomic group than the nonsurveyed junior high school; and the largest of the six elementary schools, which is situated in the same geographic region and serves the same families as the selected junior high school. The survey did not include parochial schools nor schools for Negro children.

Materials and Methods

In so far as possible, every student in each school selected was examined, except in the elementary school where only the children in grades 4, 5, and 6 were included in the survey. Out of a total enrolment of 2,657 in the grades selected, 2,600 (98 per cent) were examined; 2,560 by the senior author and the remainder by a second examiner. The age and sex distribution is shown in table 1. Boys comprised 51.6 per cent of the total. The ages ranged from 9 to 23 years with the mode at 16 years and the mean and median ages at 14.7 years.

There were 55 students who refused to cooperate in the study despite appeals made through

From the United States Naval School of Aviation Medicine, Naval Air Station, Pensacola, Fla. Opinions or conclusions contained in this report are those of the authors. They are not to be construed as necessarily reflecting the view or the endorsement of the Navy Department.

Table 1.—Age and Sex Distribution of Examined Children

Age	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Total
Boys	19	42	38	107	165	149	221	253	225	96	14	6	4	0	2	1,341
Girls	17	38	49	133	147	164	190	213	235	56	12	4	1	0	0	1,259
Total	36	80	87	240	312	313	411	466	460	152	26	10	5	0	2	2,600

their parents and family physician. In as many instances as possible, the records of the family physician were examined to determine the presence or absence of heart disease. In only 1 case was there a history of heart disease, and this case is not included in the survey. Two other students moved from Pensacola before satisfactory roentgenograms could be obtained; although the remainder of the examination was normal, they have been excluded from the total.

The parents were requested to complete a questionnaire giving details of the student's birth, past health, and the name of the family physician, if any. At the time of the examination the salient features of this questionnaire were reviewed by the examining physician, and the student was questioned regarding any symptoms of cardiovascular origin. The physical examination included measurements of height, weight, anteroposterior and transverse diameters of the chest at the level of the xiphoid process, and the blood pressure determined with the patient seated. In addition an estimate was made by the examining physician of the student's state of sexual development, which was classified as prepuberal, puberal, or postpuberal. Because of the possible effects of anxiety and overventilation on the blood pressure and on the electrocardiogram,[1,2] the mental attitude of the child was also estimated and recorded as either relaxed, moderately tense, or definitely anxious. A brief general physical examination was then performed, followed by a detailed examination of the lungs and heart; the latter was examined with the subject in both the sitting and recumbent positions. The left lateral decubitus position after exercise was used in students with a past history of rheumatic fever, in those with a loud mitral first sound or with a third sound in diastole simulating the opening snap of mitral stenosis, and in students with loud or well transmitted apical systolic murmurs.

Laboratory examinations included a six-foot roentgenogram of the chest and two electrocardiograms. The first electrocardiogram was taken with a Sanborn Viso-cardiette. Leads 1, 2, 3, aVR, aVL, aVF, and V_{1-6} were obtained. This record was reviewed immediately and a brief interpretation entered on the data sheet. The second electrocardiogram was then obtained with a Sanborn Cardiette, and, in addition to the twelve leads mentioned, CF and V leads obtained from points in the left paravertebral line at the level of V4, 5, and 6 were recorded for use in vector analysis. In selected cases a more complete electrocardiographic exploration was carried out.

At a later date a clinical interpretation was made of the roentgenogram and electrocardiogram, and in case of technical error an additional record was obtained. Quantitative measurements were made subsequently. All interesting and abnormal electrocardiograms were reviewed by the entire staff at the cardiovascular laboratory of the Naval School of Aviation Medicine; problems of interpreting the roentgenograms were referred to Naval or civilian consultants.*

When, on physical examination, the findings were definitely or possibly abnormal, or the roentgenogram or electrocardiogram suggested that some abnormality had been overlooked, the subjects were re-examined by at least two physicians. At this time a definite decision could usually be reached regarding the presence or absence of heart disease. In certain problem cases further roentgen, electrocardiographic, or laboratory studies were carried out.

The diagnosis of rheumatic heart disease was made only in the presence of characteristic murmurs. Aortic insufficiency was diagnosed when a blowing diastolic decrescendo murmur was heard along the left sternal border or in the second right interspace. Aortic stenosis was diagnosed in the presence of a harsh, grade 2 or louder systolic murmur in the second right interspace transmitted to the neck, when other murmurs characteristic of

*We are grateful to Dr. Nathan Arenson, Captain C. C. Virtue, MC, USN, and Commander Curtis Asher, MC, USN, for their advice and aid during this study.

rheumatic heart disease were heard. In the absence of other murmurs of rheumatic heart disease, aortic stenosis was not diagnosed unless a thrill was present. Mitral stenosis was diagnosed in the presence of a low-pitched, rumbling, middiastolic apical murmur, with or without presystolic accentuation. Mitral insufficiency was diagnosed in the presence of an apical systolic murmur of grade 3 intensity or louder which was transmitted toward the axilla and which did not disappear with change in body position or respiration. The diagnosis of mitral insufficiency was made in the absence of roentgenographic evidence of enlargement of the heart if there was a history of previous rheumatic fever.

Congenital heart disease was diagnosed when grade 3 or louder systolic murmurs were heard over the base of the heart or along the left sternal border, which persisted despite changes in respiration or body position. Abnormalities of the roentgenogram or electrocardiogram were considered additional evidence in favor of the diagnosis. Cases of the Wolff-Parkinson-White syndrome were classified as cases of congenital heart disease even though the roentgenogram and physical examination revealed no abnormalities. Care was taken to avoid mistaken diagnoses of heart disease based on insufficient evidence.

After the roentgenogram and electrocardiogram had been interpreted in the light of clinical findings, a report was sent to the family stating either that no abnormalities were found, or that abnormalities existed and that the family physician should be consulted. In all cases, both normal and abnormal, the family physician received a brief report of the medical, roentgenographic and electrocardiographic findings together with a portion of the Viso-cardiette record for his files.

Table 2.—Incidence of Heart Disease in School Children of Pensacola, Florida

	Number	Per Cent
Total number examined	2,600	100.00
Organic heart disease*	22	0.85
Chronic rheumatic heart disease 10 cases (0.38%)		
Congenital heart disease 10 cases (0.38%)		
Unknown etiology 2 cases (0.08%)		
Possible heart disease	4	0.15
Potential rheumatic heart disease	15	0.57
Potential syphilitic heart disease	1	0.04

*See footnote, page 33.

Results

Twenty-two of the 2,600 school children examined had definite heart disease, an over-all incidence of 0.85 per cent. Ten of the 22 had inactive rheumatic heart disease (0.38 per cent), 10 had congenital heart disease (0.38 per cent), and 2 had isolated aortic stenosis which, in the absence of a history of rheumatic fever, could not be definitely distinguished from congenital subaortic stenosis (table 2). The pertinent clinical data are given in tables 3-6. It should be noted that 2 of the cases in which the diagnosis was inactive rheumatic heart disease with mitral insufficiency would be called cases of "potential and possible rheumatic heart disease" according to the criteria of the New York Heart Association[3] because of the absence of cardiac enlargement. It is our opinion that these 2 cases, in each of which there was an undoubted history of acute rheumatic fever and a loud, harsh, holosystolic murmur transmitted to the axilla (which in 1 case had been heard over an

Table 3.—Summary of Case Histories of Children with Chronic Rheumatic Heart Disease

Case Number	Sex	Age	Years in Pensacola	History of Rheumatic Fever	Valvular Lesion	Cardiac Enlargement by Roentgenogram	Electrocardiographic Findings	Previously Diagnosed
119*	F	17	17	Yes	MI	No	Normal	Yes
173	M	17	6	No	AI, MI	No	LAD	No
194*	F	17	2	Yes†	MI	No	Normal	Yes
625	F	17	16	No	MI	Yes	Increased voltage in chest leads	Yes
1,256	F	17	9	Yes	MI	Yes	1° A-V block	Yes
1,266	F	17	17	No (RA)	MI, MS	No	Normal	No
1,271	F	18	18	No	MI	Yes	Increased voltage in chest leads	No
1,509	M	16	16	Yes	AS, MI	No	PVB's	Yes
1,763	M	14	2	Yes†	AI	No	Normal	Yes
2,451	M	14	14	Yes	AI, MI	No	Normal	Yes

*Cases 119 and 194 would be diagnosed potential and possible rheumatic heart disease according to criteria of New York Heart Association. See text.

†Rheumatic fever before coming South.

Abbreviations used in this table: F—female, M—male, MI—mitral insufficiency, AI—aortic insufficiency, MS—mitral stenosis, AS—aortic stenosis, LAD—left axis deviation, PVB's—premature ventricular beats, and RA—rheumatoid arthritis.

Table 4.—Summary of Case Histories of Children with Congenital Heart Disease

Case Number	Sex	Age	Years in Pensacola	Presumptive Diagnosis	Cardiac Enlargement	Electrocardiographic Findings	Previously Diagnosed
227	M	17	2	IASD	Yes	RBBB	Yes
402	M	16	8	IASD	Yes	Incomplete RBBB	Yes
566*	M	17	17	WPW	Yes	Short P-R, prolonged QRS	No
734*	M	16	16	WPW	No	Short P-R, slurred QRS	No
832*	F	15	15	WPW	No	Short P-R, slurred QRS	No
839*	M	17	17	WPW	No	Short P-R, prolonged QRS	No
885	M	17	17	IVSD	Yes	Slight LAD	Yes
1,232	F	16	16	IVSD	Yes	Incomplete RBBB	Yes
1,678	M	12	12	IVSD	No	Slight LAD	Yes
1,757	M	16	16	IASD	Yes	RAD	No

*See footnote this page.
Abbreviations used in this table: IASD—interauricular septal defect, IVSD—intraventricular septal defect, WPW—Wolff-Parkinson-White Syndrome, RBBB—right bundle branch block, LAD—left axis deviation, and RAD—right axis deviation.

11 year period), are more properly classed as cases of definite heart disease. It should be noted also that we have included among the cases of congenital heart disease 4 cases of the Wolff-Parkinson-White syndrome*

Four additional cases were classified as cases of possible heart disease. In 2 there was first degree heart block according to the criteria of Ashman and Hull[4] with a doubtful history of rheumatic fever: one child had a "weak heart caused by tonsils" at age 12; the other had had fever of unknown origin during which the possibility of rheumatic fever was raised despite the absence of joint pains, rash, nosebleeds and chorea. In 2 other cases there were moderately loud systolic murmurs heard maximally in the third left intercostal space near the sternal border which were well transmitted to the base but which varied markedly, although they did not disappear, with change in body position and respiration. In each case the roentgenogram and electrocardiogram were normal, and the past history was noncontributory.

The diagnosis of potential syphilitic heart disease was made in one 15 year old girl with an apparently normal cardiovascular system, who had recently completed a course of penicillin therapy for acquired syphilis. No other persons gave a history of syphilis. Since a serologic test for syphilis was not performed as part of this survey, it is possible that some cases were overlooked.

In 15 cases in which there was no evidence of heart disease, a well substantiated history was given of one or more attacks of acute rheumatic fever. In these cases the diagnosis was potential rheumatic heart disease, and the families were urged to continue to have the children examined annually. In 9 other cases in which heart murmurs were not present, the parents reported that rheumatic fever had been suspected or diagnosed, but the history of the symptoms or of the treatment, or both, when obtained during the present survey made that diagnosis seem unlikely. It is appreciated that the diagnosis of acute rheumatic fever is often difficult and that many cases occur which are unrecognized. Nevertheless, if a diagnosis of rheumatic fever is seriously entertained by a physician, bed rest of more than a few days should be enforced. Since in these 9 cases prolonged bed rest had not been required, they have not been recorded as cases of potential rheumatic heart disease.

A history of diphtheria was obtained in 44 cases. Since it is doubted that cardiac sequelae can arise after a period during which the heart is normal,[5] these cases are not classified as cases of potential heart disease.

Certain other miscellaneous conditions are worth mentioning. One 17 year old girl with an otherwise normal heart had paroxysmal ventricular tachycardia which reverted to normal only with procaine amide or quinidine therapy. Two girls, who were first cousins, had depressed ST seg-

*In order to facilitate comparison with other surveys, we append the incidence of heart disease when the 2 cases of mitral insufficiency without cardiac enlargement and the 4 cases of the Wolff-Parkinson-White syndrome are not included:

Disease	Cases	Per Cent
Rheumatic heart disease	8	0.31
Congenital heart disease	6	0.23
Unclassified heart disease	2	0.08
Total	16	0.62

Table 5.—Summary of Case Histories of Children with Heart Disease of Undetermined Etiology

Case Number	Sex	Age	Years in Pensacola	History of Rheumatic Fever	Valvular Lesion	Cardiac Enlargement	Electro-cardiographic Findings	Previously Diagnosed
326	M	16	16	No	AS only	No	Early LVH (?)	No
1,650	M	15	1	No	AS only	No	Normal	No

Abbreviations used: AS—aortic stenosis, and LVH—left ventricular hypertrophy.

ments, which proved to be a familial abnormality.[6] Twenty-eight children showed various degrees of "local T negativity"[7] in the precordial leads. A number of children had funnel chest (pectus excavatum) with apparent enlargement of the heart demonstrated roentgenologically. In several other children the heart was more than 10 per cent enlarged, as shown by teleroentgenogram, without evident cause. These various groups will be discussed in more detail in subsequent reports.

Certain noncardiac diseases were encountered: minimal tuberculosis (1 case); fibrosis of the lung (1 case); undiagnosed consolidation or calcification (4 cases); dyschondroplasia (1 case), and many cases of benign skin disorders. In these cases, the patients were referred to their family physician for further diagnosis and treatment.

Discussion

Close comparison is impossible among the numerous surveys of heart disease in school children for several reasons. The most important is the failure of many authors to state the criteria used for the selection of subjects and for the diagnosis of heart disease, especially mitral insufficiency. The different backgrounds of the examiners and the varying use of laboratory aids in the survey also make direct comparison of results difficult, as Wedum, Wedum and Beaghler[8] emphasized. The age range of the children also affects the incidence of heart disease: Young[9] in a survey of school children in Salt Lake City found a rate of 27 cases of rheumatic heart disease per thousand in the 10 to 12 year age range, while Alway,[10] using the same criteria in the same city, found 7 cases per thousand in the 15 to 18 year group. This apparent discrepancy is resolved when the figures are viewed in the light of Jones' report[11] that 20 per cent of the children with rheumatic heart disease in his series died before age 18 and that 64 per cent of those remaining showed no, or minimal, evidence of heart disease. Finally, the number of children surveyed must be taken into consideration, for in a study of a small number of students the addition or subtraction of 1 case of heart disease may profoundly affect the rate per thousand. Until large numbers of randomly selected children are examined by cardiologists using clearly defined criteria, the incidence of heart disease in children cannot be estimated with accuracy.

Despite these difficulties in comparing the reported surveys of heart disease in school children, certain general trends are evident. The incidence of rheumatic heart disease varies widely from locality to locality; this disease is more prevalent in cold moist climates and among children living under unfavorable conditions. The variation in the incidence of congenital heart disease is considerably less, a difference which is not surprising in view of what is known etiologically of these conditions. It is also noteworthy that in the studies reporting the highest incidence of congenital heart disease, the lowest total number was examined.[12,13]

When our results are compared with those of the surveys conducted by other cardiologists (table 7), it is evident that the incidence of rheumatic heart disease in Pensacola is in the same range as the reported incidence in Miami, Fla.,[13] South-

Table 6.—Summary of Case Histories of Children with Possible Heart Disease

Case Number	Sex	Age	Years in Pensacola	History of Rheumatic Fever	Murmurs	Cardiac Enlargement	Electro-cardiographic Findings	Previously Suspected
91	M	18	5	Questionable	None	No	1° A-V block	Yes
1,772	F	13	7	Questionable	None	No	1° A-V block	No
1,899	F	14	14	No	LSB	No	PVB's	No
2,130	M	12	11	No	LSB	No	Normal	Yes

Abbreviations used: LSB—left sternal border, and PVB's—premature ventricular beats.

ern Arizona,[11] and Redlands, Calif.[15] It is far less than the incidence in more Northern communities.[8,14,16] The low rate of rheumatic heart disease among the school children examined here is paralleled by a low death rate. Examination of the death certificates of persons under 20 years of age who were residents of Escambia County shows that only 6 white children were reported to have died of heart disease during a five year period (1946-1951). Four of these suffered from congenital heart disease, 1 had rheumatic heart disease, and in 1 the type of heart disease was not specified.

Although the difference in climate in general plays a major role in the variation from locality to locality, the presence of unfavorable living conditions ("micro-climate" of Danisvewsky) will tend to increase the incidence of rheumatic heart disease even in subtropical climates.[17,18] Outbreaks of epidemic rheumatic fever at Naval Training Centers throughout the country during the mobilization of World War II suggest that the "micro-climate" of these centers was at least as important as their location in the occurrence of the disease.[19] It is pertinent to point out that although Pensacola has large sections of substandard housing, the dwellings are usually one or two family types separated from neighboring houses, and there do not exist the overcrowded dark tenements found in more urban communities. In 2 of our 10 cases of rheumatic heart disease, the housing was definitely substandard and in the remainder it was adequate. In 8 of these cases rheumatic fever developed while the child was living in Pensacola.

The number of cases of rheumatic heart disease that we encountered is too small for statistical analysis, but it is of interest that in the 4 cases in which it occurred in boys involvement of the aortic valve, with or without mitral involvement, was present, while in none of the 6 cases occurring in girls were there lesions of the aortic valve. It is also striking that the only case of rheumatoid arthritis in our series occurred in 1 of the 6 girls with rheumatic heart disease.

The incidence of congenital heart disease in the present survey (0.38 per cent) is midway between the extreme of 0.07 per cent reported by Sampson, Hahman, Halverson and Shearer[15] in California, and 0.6 per cent reported in Miami by Saslaw, Ross and Dobrin[13] (table 7). If it is assumed that there is no factor in climate or local environment which affects the incidence of congenital heart disease, the variations reported in the studies listed must be the result of: (1) sampling technic, (2) criteria used, or (3) care with which the study was carried out. Surveys which report unusually low or high incidences of congenital heart disease are therefore liable to critical review. In a given survey, however, the factors which might operate to give a low or high value to the incidence of congenital heart disease should operate in similar direction with regard to rheumatic heart disease. It is thus of interest to calculate the number of cases of rheumatic heart disease for each case of congenital heart disease; in the selected surveys summarized in table 7 the ratio varies from 0.8:1 (Miami, Fla.) to 28.8:1 (Eureka, Calif.). The relative importance of the two varieties of heart disease in a given locality becomes immediately apparent. The variation in the ratio from locality to locality makes it impossible to estimate with accuracy from the inadequate data at hand the proportion of rheumatic heart disease to congenital heart disease for the country as a whole.

Table 7.—Summary of Selected Surveys Reporting the Incidence of Heart Disease in School Children

Location	Author	Number Examined	Incidence of Rheumatic Heart Disease	Incidence of Congenital Heart Disease	Ratio of Rheumatic Heart Disease to Congenital Heart Disease
Montana and Wyoming	Paul and Dixon[14]	688	4.50%	—	—
Salt Lake City, Utah	Young[9]	—	2.70%	—	—
New Haven, Conn.	Paul[16]	1,836	2.50%	—	—
Eureka, Calif.	Sampson and others[15]	2,450	2.00%	0.07%	28.8:1
Denver, Col.	Wedum and others[8]	1,845	1.63%	0.27%	6.0:1
Dublin, Ga.	Quinn[12]	401	1.00%	0.50%	2.0:1
Susanville, Calif.	Sampson and others[15]	—	1.00%	—	—
Salt Lake City, Utah	Alway[10]	1,552	0.70%	0.25%	2.8:1
Miami, Fla.	Saslaw and others[13]	1,001	0.50%	0.60%	0.8:1
Southern Arizona	Paul and Dixon[14]	1,019	0.50%	—	—
Redlands, Calif.	Sampson and others[15]	2,635	0.38%	0.08%	4.8:1
Pensacola, Fla.	Present paper	2,600	0.38%	0.38%	1.0:1

Three cases of probable interauricular septal defects and 3 cases of probable interventricular septal defects comprised the structural congenital abnormalities. We have included 4 cases of Wolff-Parkinson-White syndrome as cases of congenital heart disease, for the most commonly accepted cause of this condition is an anomalous conducting pathway between auricles and ventricles. That most reported cases are in adults rather than in children is probably explained by the fact that most electrocardiograms are obtained from adults. In a large series of electrocardiograms of healthy young men in naval service[20] the anomaly has appeared about once in 700 tracings, an incidence closely comparable to that in this series in school children (1 in 650 cases). Recently reported electrocardiographic studies of infants and children with tachycardia[21,22] indicate that it occurs in the very young and lend support to the thesis that the condition should be classified with congenital heart disease. Not until large numbers of normal children are examined with the electrocardiogram will the actual incidence of this condition be determined. Our 4 cases of the Wolff-Parkinson-White syndrome include 2 in which there were P-R intervals of 0.09 sec. and QRS durations of 0.10 sec. In 1 conduction was normal at irregular intervals. In the other 2 cases short P-R intervals (0.08 sec.) and slurred initial portions of the QRS complex were present, but the total duration of QRS was within normal limits (0.09 sec.). We have considered these cases as variants of the Wolff-Parkinson-White syndrome. In none of these 4 cases was there a history of paroxysmal tachycardia.

Although the present survey uncovered no case of heart disease amenable to surgical correction, the recent increases in the scope, safety and availability of cardiac surgery make the detection of cases of heart disease of more than mere statistical interest. These advances offer an added incentive for school, medical and public health officials to institute more widespread and continuous surveys of the cardiovascular system in school children.

Summary

The materials, methods and criteria used in conducting a cardiovascular survey of the white school children in Pensacola, Fla., are presented.

Twenty-six hundred children were examined, ranging in age from 9 to 23 years and representing 58.5 per cent of all the students enrolled in grades 4 through 12.

Twenty-two cases of organic heart disease were encountered, an incidence of 0.85 per cent. In 10 cases the disease was of rheumatic origin (0.38 per cent), in 10 of congenital origin (0.38 per cent), and in 2 of undetermined etiology (0.08 per cent). Included in the 10 cases of congenital heart disease are 4 cases of the Wolff-Parkinson-White syndrome.

The incidence of rheumatic heart disease is comparable with that reported in other surveys conducted in the Southern part of the United States, and is much lower than the rates reported from Northern areas.

Acknowledgements

We wish to thank the officials of the Florida State Board of Health and the Florida Medical Association, and the members of the Escambia County Medical Society for their active support and interest. The continuous cooperation of the principals, teachers and students of the surveyed schools is gratefully acknowledged. We are particularly indebted to Catherine F. Kasparek, B.A., and Louise V. Sharman, B.S., who not only took all the electrocardiograms and roentgenograms and measured many of them, but who also acted efficiently as receptionists, secretaries and bibliographers. Our thanks are also due to the many hospital corpsmen of the United States Navy who aided in processing the roentgenograms and electrocardiograms.

References

1. Mainzer, F., and Krause, M.: Influence of Fear on Electrocardiogram, Brit. Heart J. 2:221-230 (Oct.) 1940.
2. Thompson, W. P.: Electrocardiogram in Hyperventilation Syndrome, Am. Heart J. 25:372-390 (March) 1943.
3. New York Heart Association, Criteria Committee: Nomenclature and Criteria for Diagnosis of Diseases of the Heart, ed. 4, New York Tuberc. & Health Assoc., 1939.
4. Ashman, R., and Hull, E.: Essentials of Electrocardiography for the Student and Practitioner of Medicine, ed. 2, New York, The Macmillan Company, 1941.
5. Stimson, P. M.: A Manual of the Common Contagious Diseases, ed. 3, Philadelphia, Lea and Febiger, 1940.
6. To be published.
7. Grant, R. P.; Estes, E. H., Jr., and Doyle, J. T.: Spatial Vector Electrocardiography; The Clinical Characteristics of S-T and T Vectors, Circulation 3:182-197 (Feb.) 1951.
8. Wedum, B. G.; Wedum, A. G., and Beaghler, A. L.: Prevalence of Rheumatic Heart Disease in Denver School Children, Am. J. Pub. Health 35:1271-1276 (Dec.) 1945.
9. Young, W. R.: Unpublished data, cited by Alway, R. H.[10]
10. Alway, R. H.: Personal communication.
11. Jones, T. D.: Heart Disease in Childhood, Am. J. Pub. Health 28:637-643 (May) 1938.
12. Quinn, R. W.: Incidence of Rheumatic Fever and Heart Disease in School Children of Duhlin, Georgia, with Some Epidemiological and Sociological Observations, Am. Heart J. 32:234-242 (Aug.) 1946.
13. Saslaw, M. S.; Ross, B. D., and Dobrin, M.: The Incidence of Rheumatic Heart Disease in Native School Children of Dade County, Florida, Am. Heart J. 40:760-765 (Nov.) 1950.
14. Paul, J. R., and Dixon, G. L.: Climate and Rheumatic Heart Disease; Survey Among American Indian School Children in Northern and Southern Localities, J. A. M. A. 108:2096-2100 (June 19) 1937.
15. Sampson, J. J.; Hahman, P. T.; Halverson, W. L., and Shearer, M. C.: Incidence of Heart Disease and Rheumatic Fever in School Children in Three Climatically Different California Communities, Am. Heart J. 29:178-204 (Feb.) 1945.
16. Paul, J. R.: Tabulated by Wedum and co-workers.[8]
17. Francisco, R.: Rheumatic Heart Disease in Tropics with Special Reference to Its Incidence in Puerto Rico, Clinics 5:971-984 (Dec.) 1946.
18. Paul, J. R.: The Epidemiology of Rheumatic Fever and Some of Its Public Health Aspects, ed. 2, New York, 1943, Printed for the American Heart Association by the Metropolitan Life Insur. Co.
19. Graettinger, J. S.; Seal, J. R.; Ware, R. L., and Charter, W. V.: Rheumatic Fever in the Navy, Naval Medical Research Unit No. 4, Project No. NM 005 051.04.03, 1950.
20. Graybiel, A.: Unpublished data.
21. Richmond, J. B.; Moore, H. R., and Collen, I. R.: Wolff-Parkinson-White Syndrome in Infant, Pediatrics 1:635-642 (May) 1948.
22. Silverman, J. J., and Werner, M.: Fatal Paroxysmal Tachycardia in a Newborn Infant with the Wolff-Parkinson-White Syndrome, J. Pediat. 37:765-773 (Nov.) 1950.

United States Naval Air Station.

A Note on New Drugs, "Miracle" and Otherwise, For Tuberculosis

Henry C. Sweany, M.D.
TAMPA

The recent dramatic announcement of the new "miracle" drug for tuberculosis was unfortunate from many viewpoints. The newspaper men cannot be blamed, for news is their business, but it was entirely inappropriate for medical men to sponsor a "press conference" that may cause disservice to the patients who are victims of the disease.

First of all, it was premature and unnecessary to tell about a drug of such fantastic repute, months before it could become available, even if every claim proves to be true. Patients always "grasp at straws" and are liable to quit their treatment, call off their surgery and go in search of the "new salvation."

It might be well to point out a few of the possibilities based on past experience. It should be remembered that streptomycin produced favorable effects at first that did not persist. A feeling of exhilaration was experienced by the patient, and in many cases there were decided clinical changes; but there was also a large percentage, perhaps a majority, of cases in which exacerbations occurred, and the patients were saved, if at all, only by strict rest and/or surgery and other drugs. It was necessary to throw many safeguards around the treatment and keep the patient at rest almost the same as before the drugs were used.

Another illustration may be cited to show how illusory may be this old disease. The effect of ACTH and cortisone on advanced tuberculous patients is a case in point. The patients in general not only feel better, but they have ravenous appetites and gain much weight for a while, but the disease progresses on to death. This outcome proves that feeling well does not mean the patient actually is well. The effect of these two compounds on tuberculosis is one of the greatest "Trojan horses" of medicine. It is our duty to watch for others.

Now assuming that the drug is all that is said of it, and that it even kills every tubercle bacillus within its reach, there will be large "abscesses" or cavities in about 70 per cent of the cases, which will need surgery to close them up. The surgery will be increased many fold. Instead of less care in hospitals, there will be more; instead of fewer beds, there will be a need for more, for a while at least, until the present number of cases receive adequate care. This need may last for several years. During this time the case-finding program must go on unabated, or actually be stepped up.

In all probability the drug will fall short of the perfect score that has been reported, and it will have to be handled similarly to other remedies of the recent past. There has not been time enough yet to determine drug resistance or late toxicity.

Finally, there are going to be many errors in diagnosis. Some cases will be complicated by other disease, such as abscess, bronchiectasis, cancer, or mycotic disease, and combination treatment will be necessary, or other treatment, such as surgery, will be the only therapy available. Under any of these conditions, the present methods must still be used to the fullest extent.

A warning to patients and a word of caution to general practicing physicians are incumbent upon all of us who understand better the ancient disease, tuberculosis, so that general panic does not develop in our hospitals, and in tuberculous patients everywhere.

As an anticlimax to this brief discussion, it may be appropriate to point out some of the latest combinations of antibiotics and chemotherapy, so that physicians using antibiotics in the treatment of tuberculosis will be able to obtain a maximum of benefit with a minimum of toxic or other deleterious effects as a result of the treatment.

As to the preference of streptomycin or dihydrostreptomycin, the evidence now seems to point to less toxicity of the latter with perhaps slightly less effectiveness gram for gram than for streptomycin. A gram and a half of dihydrostreptomycin, however, may be given with even less chance of toxic effect than 1 Gm. of streptomycin. Nevertheless, most clinics seem to favor streptomycin, but there is really little difference. Another point

Chief Medical Director, State Tuberculosis Board.
From the Southwest Florida Tuberculosis Hospital, Tampa.

is that streptomycin and dihydrostreptomycin given twice a week are as effective as when given daily.

The most important recent data[1,2] explain the protection that para aminosalicylic acid (PAS) gives to streptomycin against the development of bacterial resistance and vice versa. One gram of streptomycin twice a week and 12 Gm. of PAS daily, given in four equal doses, have been found to develop only about 15 per cent bacillary resistance for both streptomycin and PAS over a four month period, whereas streptomycin alone will develop about 80 per cent and PAS alone about 50 per cent resistance when given alone during the same period of time.

It is definitely not proper any more, therefore, to give either drug alone because after full resistance develops, further treatment with the particular drug is practically useless. When patients come to the hospitals with resistant bacilli, the treatment is more difficult, and the chances of recovery are greatly decreased. The commonest regimen now is to give streptomycin in 1 Gm. dosage twice a week and PAS in 12 Gm. dosage four times a day.

References

1. Tempel, C. W., and others: Combined Intermittent Regimens Employing Streptomycin and Para Aminosalicylic Acid in the Treatment of Pulmonary Tuberculosis: A Comparison with Daily and Intermittent Dosage Schedules, Minutes of the Ninth Streptomycin Conference, Veterans Administration, April 18, 1950, St. Louis, Mo.
2. Mardis, R. E., and others: A Combined Intermittent Regimen Employing Streptomycin and Para Aminosalicylic Acid in the Treatment of Pulmonary Tuberculosis: A Follow-up Study, Minutes of the Tenth Streptomycin Conference, Veterans Administration, January 25, 1951, Atlanta, Ga.

Route 4, Box 695.

Allergy Survey of Florida in the Light of Present Knowledge

CLARENCE BERNSTEIN, M.D.
AND
SOLOMON D. KLOTZ, M.D.
ORLANDO

In connection with the preparation of a regional allergy survey of the United States now being undertaken by the University of Illinois, we were asked to bring together current information regarding allergy in Florida. This presented a difficult assignment in several particulars:

1. The aerobiology of Florida has not been fully covered by extended observations.
2. Various observers using different methods and technics have contributed to our still relatively meager knowledge in this field.
3. The correlation between observed allergens and clinical symptomatology is often not demonstrable.
4. Differences in regions of Florida itself are so great that each area merits investigation by itself.

Such a study warrants single or unified over-all supervision and the use of standard, uniform methods. It is our hope that this study may make some contribution to the endeavor and at the same time point up the need for further explorations in this field. The material presented herein is a digest of the work and opinions of representative men in this field gathered by survey based on personal contact and communication.

We have exposed slides daily for over two years, employing a standardized slide holder for pollen capture. The slides are then studied and the daily counts recorded. We have also exposed agar plates both indoors and out-of-doors for twenty minute periods and recorded the resultant mold growth identified later. Some observations have been carried on at other locations, notably at twenty posts of the Florida State Board of Health, Division of Industrial Hygiene, and weather stations under Dr. John M. McDonald, and as regards molds by Drs. Lewis Palay and Nelson Zivitz of Miami Beach. The early studies of the air-borne pollens were pioneered in this state by Mr. O. C. Durham of the Abbott Laboratories, and by Dr. Frank C. Metzger of Tampa. We are happy to make grateful acknowledgment of the work of all of these contributors.

Geography

Florida is primarily a peninsula of low-lying rather flat sandy terrain. It is continually swept

Presented before the Florida Academy of Sciences, Fifth Annual Meeting, University of Tampa, Tampa, Nov. 30, 1951.

by winds whose direction and velocity strikingly influence the over-all allergic symptomatology in the area.

Except for the capital, Tallahassee, and Orlando near the center of the peninsula, the principal cities are along the coast, likewise the population centers. Even the largest cities are not classifiable as manufacturing centers. Oil, gas or electricity is used for heating in general. Hence smog is no problem. Despite the abundant rainfall, much fertilization of the soil is needed, and because of the moisture and multitudinous varieties of insects and parasites, spraying of crops, homes and brackish waters adds further complications to those already arranged by nature.

Special Allergy Problems

As a rule pollen counts are low in Florida, especially in the southern two thirds of the state. Patients coming in from other areas note prompt benefit in most instances and it appears to be largely on this quantitative basis. This factor cannot be too strongly emphasized as it is the principal advantage of Florida for the severely grass- or ragweed-sensitive patient from the North and Middle West. This region continues to offer relief to that group of patients, who, over the years, have sung the praises of the state as a hay fever and asthma haven.

Florida deserves special consideration allergically because it affords predominantly an out-of-doors existence. House dust is a problem only during the few winters when the weather may be cold or confining for longer than the usual brief periods. Even so, mold in the dust is more important than the usual linters and other materials, since overstuffed furniture and wool carpeting are less commonly used. Homes are likewise widely open to gusty winds. One also finds sand rather than silt or earth deposits in the accumulated detritus in the homes, and being heavy and larger than the particles of ordinary household dirt, it seldom gets into the circulating air. Being heavy, it even holds down the lighter particles in ordinary dust. Of signal importance is the fact that there is no snow or killing frost in the area except rarely or for short durations.

There is no "quiet period" in the outdoor air. On the contrary, the lush vegetation, the moss and large leaves will hold the pollen grains longer or arrest their flight only to have them picked up by a later gust. The sumacs and ligustrums, the poison oaks and ivies offer abundant contacts for skin irritations. The thunderwood, and, at one time, the manchineel are extremely toxic for humans. Dermatitis from prolonged exposure to muck and the various eruptions from direct parasitic invasion, such as "creeping eruptions," all occur with fair frequency. Skin and respiratory difficulties from exposure to sprays used to protect groves, crops, or nursery plants are encountered several times during any year. Allergy to sunlight is rather less common than the high incidence of exposure here might lead one to expect, and when suspected, porphyria must be ruled out.

In general one might say that in Florida the allergies to inhalants are less explosive or fulminant than in the North, and certainly less than in the Middle West. This difference is perhaps due to the generally lower pollen counts and to the reduced range of temperature changes between the seasons as well as between indoor and outdoor air. Likewise, pollen dosages in treatment go to higher levels generally in order to gain a satisfactory result. "X-hay fever," observed in all the Gulf States, occurs in the fall in Florida and is an often described, little understood clinical entity.

Molds and Pollens

Compared to other areas of the United States, allergically Florida is still relatively "terra incognita." There are so many types of vegetation and pollens, some of the latter insect-borne, and so many varieties of molds and opportunities for their growth and sporulation, that any final appraisal of the air content at this date would be woefully incomplete. Work is in progress to gain fuller information. The puzzling entity, X-hay fever, is not

Table 1.—Principal Pollen and Mold Allergens of Florida

Grasses	Trees
Bermuda	Pecan
Johnson	Oaks
Timothy	Alder
St. Augustine	Australian pine (S. Florida)
Natal	Grounsel bush
Rye	
And others, especially pasturage	

Weeds	Molds
Dwarf ragweed	Aspergilli
Giant ragweed (not in Mid and South Florida)	Monilia
	Mucor
English plantain	Penicillia
Spiny amaranth	Alternaria
Redroot pigweed	Cladosporium
Lamb's quarters	Pullularia
Jerusalem oak	Helminthosporium
Sheep sorrel	Gliocladium
Yellow dock	Fusaria
Water hemp (Acnida cannabina)	Rhizopus
	Streptomyces
Iresine celosia	Torula

yet solved. Wind direction makes a great deal of difference in allergic symptoms, and may be used to advantage in gaining relief for a patient. An easterly wind brings in completely clean air to the East Coast and can be counted on frequently to relieve the ragweed-harassed patient who is sent there for a few days if, of course, he is not too mold-sensitive when indoors.

In the northern districts, pecan pollen presents a seasonal problem in the late winter and early spring. The oaks cause more trouble in northern and central areas, less in the southern districts. Molds are less a problem in the northern and central than in the southern sections and are heavier in summer and early fall in connection with the rainy season. On the coasts, however, and in moist areas mold is always to be reckoned with. Some home owners regularly through the wet seasons, even when hot, light their heaters and run them high for twenty-four to forty-eight hours, in order to "dry out the house." Some of them believe they "lick the mold problem" this way. The various true pines, such as slash and spruce, which pollinate in the spring, have at times been thought to be important offenders, and the pollens appear on slides in some areas in appreciable quantities. There is some clinical correlation, however, with aerial incidence of Australian pine (*Casuarina spp.*) pollen which has been found to be active often enough in the Miami area to warrant its use in treatment. There is the occasional report of eucalyptus sensitivity, and in local areas of sensitivity to mangrove, melaleuca and sea myrtle. Both the leaf and pollen of the Brazilian pepper tree have been considered allergenic.

Summary

The aerobiology of Florida is still relatively unexplored and needs more intensive and extensive study. The counts given in table 2 represent pooled averages and show the low pollen counts for the state as a whole. These low counts make Florida a relative haven for the typical Northern and Midwestern hay fever and asthma sufferer.

A breakdown of the pollen findings by regions into the northern, middle and southern zones with approximately one third of the state in each shows that South Florida has practically no ragweed, some Australian pine and grass pollens, and appreciable quantities of molds. Mid-Florida has less mold, slightly more grass and appreciably larger amounts of ragweed pollen. The oak season is clinically important, while Australian pine is as yet no great problem. The North Florida zone is more like the Southeastern United States in general, with less mold, slightly more ragweed and a heavier tree season, notably pecan.

The entire Florida East Coast, favored increasingly from North to South by a prevailing east wind, shows lower counts, especially in the Miami area. Habitations along the coast, how-

Table 2.—Significant Pollens and Molds in Florida — Season and Counts[1]

Month	J	F	M	A	M	J	J	A	S	O	N	D
Oak	5 +	237 +++	194 +++	27 ++	3 +							
Grasses[2]	16 +	20 +	24 +	65 ++	90 ++	43 ++	58 ++	41 ++	49 ++	32 ++	9 +	3 +
Ragweed					6 +	9 +	27 ++	73 ++	51 ++	21 ++	13 ++	
Amaranth		+ 			+	+	+					
Australian pine	13 +	13 +	40 ++	++	+	+						
Alder	+ 	++ 										
Molds	+ 						+ 	++ 	++ 	++ 	+ 	+
All others[3]	102	227	90	51	56	10	15	12	11	6	7	4

1. Based on counts reported from over the state and on twenty statewide observation posts of the Florida State Board of Health, Division of Industrial Hygiene. These estimates are subject to constant revision as further data yielding sounder "averages" are obtained. Plus marks indicate months found and are at best only roughly quantitative.
2. Undifferentiated in counts. Types found are indicated in tabulation of Florida grasses (table 1).
3. Unidentified material including mold spores, smuts and insect eggs and larvae.

ever, are notably moldier. It should be borne in mind that despite fine efforts at standardization, the interpretation of all "counts" is fraught with inaccuracies due to variations in station location, apparatus, counting method, and the observer himself.

In general, Florida is a good area for victims of allergy, not only because of the aforementioned low pollen counts, but because of the reduced temperature ranges found over the state, both as between seasonal extremes and from day to day, likewise from indoors to outdoors throughout the year. This, again, follows the zonal distribution, giving the southernmost area a slight advantage in this regard also.

It is evident from the foregoing, however, that allergy is here to stay. Since we must live with it, it becomes increasingly urgent that from our collective and coordinated efforts we gather a great deal more information about it.

In the preparation of this survey we are grateful for the help of Dr. W. Ambrose McGee, West Palm Beach, Mrs. Babette F. Bernstein, Orlando, Dr. Hal Davison, Atlanta, Ga., and Ronald J. Mann, M.S., New Orleans, La.

740 North Magnolia Avenue

ABSTRACTS OF MEDICAL ARTICLES

Pheochromocytoma: Report of a Malignant Case (Pheochromoblastoma). By Frank J. Pyle. J. Urol. 66:153-162 (Aug.) 1951.

This article contains a brief review of the anatomy, embryology and physiology of the adrenal medulla and a report of a case of malignant pheochromocytoma or pheochromoblastoma. The author states that an adrenal medullary tumor is to be suspected in all cases of paroxysmal hypertension and observes that in difficult cases in which one cannot produce an attack, it may be induced by the injection of histamine, mecholyl or tetra-ethyl-ammonium chloride. He finds the injection of adrenergic drugs such as benzodioxane or dibenamine an extremely valuable diagnostic aid.

Fatalities from Hydrogen Sulfide in Wells. By John M. McDonald, M.D., and A. P. McIntosh. A. M. A. Archives of Industrial Hygiene and Occupational Medicine 3:445-447 (May) 1951.

A tragic incident is recounted which emphasizes the serious toxicity of hydrogen sulfide, encountered mostly as an annoying nuisance in many locations in Southern Florida. This gas often escapes when a pile driver penetrates through filled earth and strikes the underlying mangrove swamp. In vegetable packing plants the wash water from either deep or shallow wells often gives off enough hydrogen sulfide to irritate the eyes of workers alongside the washer. Also, in some open bodies of water, sulfur springs and decaying vegetation combine to produce enough hydrogen sulfide to darken the paint on boats as well as on houses on the shore.

An instance is reported in which the task of cleaning a well, which was part of the water supply of a vegetable packing plant in the Everglades near Lake Okeechobee, resulted in 3 fatalities. The first laborer who went down to shovel mud into the bucket was seen to fall forward in the mud and water at the bottom of the well. Two others who went to the rescue likewise collapsed. The primary cause of death in all 3 cases was given as drowning. Autopsies were not performed. Although it is therefore impossible to estimate the role of hydrogen sulfide in the causation of the deaths, it is known that this gas has a paralytic action on the respiratory center.

The Florida Industrial Commission and the State Board of Health made a combined investigation of the accident. The authors list seven safety precautions for use in cleaning dug wells, which have now been adopted to prevent similar accidents. They also summarize in tables the readings made with M.S.A. type of hydrogen sulfide detector at the time of the investigation and the climatic conditions prevailing at the time of the accident.

FLORIDA MEDICAL ASSOCIATION

OFFICERS AND COMMITTEES

OFFICERS

ROBERT B. MCIVER, M.D., President.....*Jacksonville*
FREDERICK K. HERPEL, M.D., Pres.-elect..*West Palm Beach*
FRANCIS H. LANGLEY, M.D., 1st Vice Pres...*St. Petersburg*
ERASMUS B. HARDEE, M.D., 2nd Vice Pres.....*Vero Beach*
H. QUILLIAN JONES, M.D., 3rd Vice Pres.....*Fort Myers*
SAMUEL M. DAY, M.D., Sec'y-Treas.....*Jacksonville*
SHALER RICHARDSON, M.D., Editor.....*Jacksonville*

MANAGING DIRECTOR

STEWART G. THOMPSON, D.P.H.....*Jacksonville*
ERNEST R. GIBSON, Assistant.....*Jacksonville*

BOARD OF GOVERNORS*

ROBERT B. MCIVER, M.D., Chm...(Ex Officio).*Jacksonville*
JAMES L. BORLAND, M.D...AL-53.....*Jacksonville*
DUNCAN T. MCEWAN, M.D...B-53.....*Orlando*
JAMES H. POUND, M.D...A-54.....*Tallahassee*
NORVAL M. MARR, M.D...C-55.....*St. Petersburg*
JOHN D. MILTON, M.D...D-56.....*Miami*
HERBERT E. WHITE, M.D...PP-53.....*St. Augustine*
DAVID R. MURPHEY, JR., M.D...PP-54.....*Tampa*
FREDERICK K. HERPEL, M.D. (Ex Officio).*W. Palm Beach*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*
HERBERT L. BRYANS, M.D...S.B.H.-53.....*Pensacola*
STEWART G. THOMPSON, D.P.H. (Advisory)...*Jacksonville*

*SUB-COMMITTEES

1. Veterans Care

FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
GEORGE M. STUBBS, M.D.....*Jacksonville*
DOUGLAS D. MARTIN, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

2. Liaison — National Foundation Infantile Paralysis

FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
A. JUDSON GRAVES, M.D.....*Jacksonville*
H. PHILLIP HAMPTON, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

3. Review of Fee Schedules

JOHN D. MILTON, M.D., Chm.....*Miami*
WOODROW B. ESTES, M.D.,.....*St. Petersburg*
FREDERICK H. BOWEN, M.D.....*Jacksonville*
ODIS G. KENDRICK, JR., M.D.....*Tallahassee.*
JAMES B. GLANTON, M.D.....*Orlando*
FLOYD K. HURT, M.D.....*Jacksonville*
HERSCHEL G. COLE, M.D.....*Tampa*
A. FRANKLIN HARRISON, M.D.....*Madison*
JACK O. W. RASH, M.D.....*Miami*
KENNETH S. WHITMER, M.D.....*Miami*
ADELBERT F. SCHIRMER, M.D.....*Orlando*

1. Blue Shield

LEIGH F. ROBINSON, M.D., Chm.....*Fort Lauderdale*

SCIENTIFIC WORK

JAMES N. PATTERSON, M.D., Chm...AL-53.....*Tampa*
CAROL C. WEBB, M.D...A-53.....*Pensacola*
FREDERICK K. HERPEL, M.D...D-54.....*West Palm Beach*
JERE W. ANNIS, M.D...C-55.....*Lakeland*
RICHARD C. CUMMING, M.D...B-56.....*Ocala*

LEGISLATION AND PUBLIC POLICY

EUGENE G. PEEK, SR., M.D., Chm...B-54.....*Ocala*
WILLIAM M. ROWLETT, M.D...AL-53.....*Tampa*
DANIEL A. MCKINNON, M.D...A-53.....*Marianna*
ANGUS D. GRACE, M.D...C-55.....*Fort Myers*
DONALD W. SMITH, M.D...D-56.....*Miami*
ROBERT B. MCIVER, M.D. (Ex Officio).....*Jacksonville*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*

MEDICAL EDUCATION AND HOSPITALS*

JACK Q. CLEVELAND, M.D., Chm...AL-53.....*Coral Gables*
JULIUS C. DAVIS, M.D...A-53.....*Quincy*
ELBERT MCLAURY, M.D...D-54.....*Hollywood*
S. CARNES HARVARD, M.D...C-55.....*Brooksville*
BENJAMIN F. DICKENS, M.D...B-56.....*Fernandina*

*SPECIAL ASSIGNMENT

1. Urge Gifts to American Medical Education Foundation

PUBLIC RELATIONS*

EUGENE B. MAXWELL, M.D., Chm...AL-53.....*Tampa*
LEIGH F. ROBINSON, M.D...D-53.....*Fort Lauderdale*
HOWARD V. WEEMS, SR., M.D...C-54.....*Sebring*
EUGENE G. PEEK, JR., M.D...B-55.....*Ocala*
HENRY L. SMITH, JR., M.D...A-56.....*Tallahassee*

*SPECIAL ASSIGNMENTS

1. Rural Educational Program
2. State Education Campaign

NECROLOGY

ALVIN L. STEBBINS, M.D., Chm...A-56.....*Pensacola*
HUGH WEST, M.D...AL-53.....*DeLand*
JOSEPH HALTON, M.D...C-53.....*Sarasota*
WALLACE H. MITCHELL, M.D...D-54.....*Key West*
JOSEPH J. LOWENTHAL, M.D...B-55.....*Jacksonville*

MEDICAL POSTGRADUATE COURSE

TURNER Z. CASON, M.D., Chm...B-55.....*Jacksonville*
ARTHUR J. BUTT, M.D...AL-53.....*Pensacola*
FRANZ H. STEWART, M.D...D-53.....*Miami*
J. BROWN FARRIOR, M.D...C-54.....*Tampa*
FRANCIS T. HOLLAND, M.D...A-56.....*Tallahassee*

CANCER CONTROL

FRAZIER J. PAYTON, M.D., Chm...D-54.....*Miami*
MILTON C. MALONEY, M.D...AL-53.....*Jacksonville*
ROBERT L. TOLLE, M.D...B-53.....*Orlando*
GEORGE W. MORSE, M.D...A-55.....*Pensacola*
WESLEY W. WILSON, M.D...C-56.....*Tampa*

MEDICAL ECONOMICS

REUBEN B. CHRISMAN, JR., M.D., Chm...AL-53....*Miami*
JOHN E. MAINES, JR., M.D...B-53.....*Gainesville*
HARRISON A. WALKER, M.D...D-54.....*Miami*
WILLIAM H. WALTERS, JR., M.D...C-55.....*Lacoochee*
WILLIAM C. ROBERTS, M.D...A-56.....*Panama City*

VENEREAL DISEASE CONTROL

MELVIN M. SIMMONS, M.D., Chm...C-55.....*Sarasota*
JOHN R. BROWNING, M.D...AL-53.....*Jacksonville*
JOHN C. MCSWEEN, JR., M.D...A-53.....*Pensacola*
WILEY M. SAMS, M.D...D-54.....*Miami*
DAVID W. GODDARD, M.D...B-56.....*Daytona Beach*

TUBERCULOSIS AND PUBLIC HEALTH*

RALPH S. SAPPENFIELD, M.D., Chm...AL-53.....*Miami*
PHILLIP W. HORN, M.D...B-53.....*Jacksonville*
ERASMUS B. HARDEE, M.D...D-54.....*Vero Beach*
LOUIS J. GARCIA, M.D...C-55.....*Tampa*
HARRY S. HOWELL, M.D...A-56.....*Lake City*

*SPECIAL ASSIGNMENT

1. Diabetes Control

STATE CONTROLLED MEDICAL INSTITUTIONS

William D. Rogers, M.D., Chm...A-56....*Chattahoochee*
James L. Anderson, M.D...AL-53.....*Miami*
Bailey B. Sory, Jr., M.D...D-53.....*Palm Beach*
James G. Lyerly, M.D...B-54.....*Jacksonville*
Samuel G. Hibbs, M.D...C-55.....*Tampa*

MATERNAL WELFARE

E. Frank McCall, M.D., Chm...B-56.....*Jacksonville*
T. Bert Fletcher, Jr., M.D...AL-53.....*Tallahassee*
Lowrie W. Blake, M.D...C-53.....*Bradenton*
John N. Sims, Sr., M.D...A-54.....*Live Oak*
Ralph W. Jack, M.D...D-55.....*Miami*

CHILD HEALTH

Luther W. Holloway, M.D., Chm...B-53....*Jacksonville*
James R. Boulware, Jr., M.D...AL-53.....*Lakeland*
Warren W. Quillian, M.D...D-54.....*Coral Gables*
Daniel F. H. Murphey, M.D...C-55.....*St. Petersburg*
Courtland D. Whitaker, M.D...A-56.....*Marianna*

CONSERVATION OF VISION

Ralph N. Greene, Jr., M.D., Chm...AL-53..*Jacksonville*
William Y. Sayad, M.D...D-53.....*West Palm Beach*
Sherman B. Forbes, M.D...C-54.....*Tampa*
G. Tayloe Gwathmey, M.D...B-55.....*Orlando*
Mozart A. Lischkoff, M.D...A-56.....*Pensacola*

ADVISORY TO WOMAN'S AUXILIARY

C. Robert DeArmas, M.D., Chm...B-55....*Daytona Beach*
Benjamin H. Sullivan, M.D...AL-53.....*St. Petersburg*
Edward F. Shaver, M.D...C-53.....*Tampa*
James L. Anderson, M.D...D-54.....*Miami*
Taylor W. Griffin, M.D...A-56.....*Quincy*

REPRESENTATIVES TO INDUSTRIAL COUNCIL*

Charles R. Burbacher, M.D., Chm...D-55..*Coral Gables*
Fred H. Albee, Jr., M.D...AL-53.....*Orlando*
G. Frederick Oetjen, M.D...B-53.....*Jacksonville*
Chas. L. Farrington, M.D...C-54.....*St. Petersburg*
Lee Sharp, M.D...A-56.....*Pensacola*

*SPECIAL ASSIGNMENT

1. *Industrial Health*

COUNCILOR DISTRICTS AND COUNCIL

Eugene G. Peek, Jr., M.D., Chm...AL-53.....*Ocala*
First—Francis M. Watson, M.D...1-54.....*Marianna*
Second—Benjamin A. Wilkinson, M.D...2-53..*Tallahassee*
Third—William C. Thomas, Jr., M.D...3-54..*Gainesville*
Fourth—Eugene L. Jewett, M.D...4-53.....*Orlando*
Fifth—Hugh G. Reaves, M.D...5-53.....*Sarasota*
Sixth—Emmett E. Martin, M.D...6-54.....*Haines City*
Seventh—Erasmus B. Hardee, M.D...7-54....*Vero Beach*
Eighth—Donald W. Smith, M.D...8-53.....*Miami*

GRIEVANCE COMMITTEE

Walter C. Payne, M.D., Chm.....*Pensacola*
David R. Murphey, Jr., M.D.....*Tampa*
Herbert E. White, M.D.....*St. Augustine*
Joseph S. Stewart, M.D.....*Miami*
William C. Thomas, Sr., M.D.....*Gainesville*

ADVISORY TO SELECTIVE SERVICE FOR PHYSICIANS AND ALLIED SPECIALISTS

J. Rocher Chappell, M.D., Chm.....*Orlando*
Thomas H. Bates, M.D..."A".....*Lake City*
Frank L. Fort, M.D..."B".....*Jacksonville*
Alvin L. Mills, M.D..."C".....*St. Petersburg*
John D. Milton, M.D..."D".....*Miami*

EMERGENCY MEDICAL SERVICE

James L. Borland, M.D., Chm.....*Jacksonville*
Merritt R. Clements, M.D..."A".....*Tallahassee*
Vernon A. Lockwood, M.D..."B".....*St. Augustine*
Herschel G. Cole, M.D..."C".....*Tampa*
Frederick K. Herpel, M.D..."D".....*West Palm Beach*

A.M.A. HOUSE OF DELEGATES

Homer L. Pearson, Jr., M.D., Delegate.....*Miami*
Frank D. Gray, M.D., Alternate.....*Orlando*
(Terms expire Dec. 31, 1952)

Louis M. Orr, II, M.D., Delegate.....*Orlando*
Joshua C. Dickinson, M.D., Alternate.....*Tampa*
(Terms expire Dec. 31, 1953)

Herbert L. Bryans, M.D., Delegate.....*Pensacola*
Thomas H. Bates, M. D., Alternate.....*Lake City*
(Terms expire Dec. 31, 1955)

BOARD OF PAST PRESIDENTS

William E. Ross, M.D., 1919.....*Jacksonville*
H. Marshall Taylor, M.D., 1923.....*Jacksonville*
John C. Vinson, M.D., 1924.....*Fort Myers*
John S. McEwan, M.D., 1925.....*Orlando*
H. Mason Smith, M.D., 1926.....*Tampa*
John A. Simmons, M.D., 1927.....*Arcadia*
Frederick J. Waas, M.D., 1928.....*Jacksonville*
Julius C. Davis, M.D., 1930.....*Quincy*
William M. Rowlett, M.D., Chm., 1933.....*Tampa*
Homer L. Pearson, Jr., M.D., 1934.....*Miami*
Herbert L. Bryans, M.D., 1935.....*Pensacola*
Orion O. Feaster, M.D., 1936.....*Renton, Wash.*
Edward Jelks, M.D., 1937.....*Jacksonville*
W. Henry Spiers, M.D., 1938.....*Orlando*
Leigh F. Robinson, M.D., 1939.....*Fort Lauderdale*
Walter C. Jones, M.D., 1941.....*Miami*
Eugene G. Peek, Sr., M.D., 1943.....*Ocala*
John R. Boling, M.D., 1944, 1945.....*Tampa*
Shaler Richardson, M.D., 1946.....*Jacksonville*
William C. Thomas, Sr., M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne, M.D., 1949.....*Pensacola*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey, Jr., M.D., Sec'y., 1951.....*Tampa*

From Our President

Laughter Oils Life's Engine

How would you describe laughter? Is it "a movement of the muscles of the face, especially of the lips, indicating merriment, satisfaction, or derision, and attended by explosive sounds from the throat?" Webster says it is. Dorland's Medical Dictionary defines it as "a series of spasmodic and partly involuntary expirations with inarticulate vocalization, normally indicative of merriment."

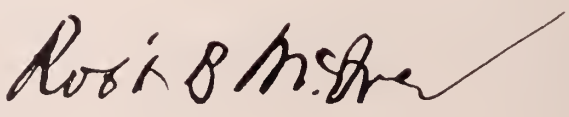
Laughter is of the body, of course, but how much more of the spirit? Someone has said: "The sense of humor is the oil of life's engine. No lot is so hard, no aspect of things so grim, but it relaxes before a hearty laugh." So laughter has power, a constructive, driving, uplifting, yes, spiritual power. It can transform the seemingly unbearable into something bearable, even hopeful. It binds men together in a kind of secret free masonry. Haven't you heard it travel around a circle and then noticed that, however large the circle, it becomes forthwith a closed circle? Sometimes it has appeal beyond reason, prejudice and cynicism. Again, it returns a sense of proportion to a troubled mind, for it erases self pity, self justification, self importance.

These are some of the attributes of laughter described by Bob Hope,[1] who surely ought to know. Perhaps its most important quality, he finds, is the ability to bring back the will to live — and, when the time comes, to give one the courage to go with good cheer. What physician at the bedside has not shared the feeling of Charles Lamb, who "jested that he might not weep?"

Too, the famous comedian finds in the power of laughter a kind of geniality that brings mirth and confidence, for "geniality might be defined as strength to spare." What an attribute for the practitioner of medicine — strength to spare, and to share. Thrice blessed is he who spontaneously keeps life's engine well oiled with wholesome laughter.

"The power of laughter," says Hope, "lies in its ability to lift the spirit. For laughter cannot exist with clipped wings. It cannot be dictated to. It must be spontaneous and free as the air you breathe. Thus it is a special property of free men in a free land who are able to laugh at anything . . . or any one . . . especially themselves."

1. Hope, Bob: Why Laughter Has Power, Guideposts (June) 1952.



The Journal of the
Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. BOX 1018 JACKSONVILLE, FLORIDA

Editor
Shaler Richardson, M.D.

Assistant Editors
Webster Merritt, M.D.
Franz H. Stewart, M.D.

Associate Editors
Louis M. Orr, II, M.D. ..... Orlando
Joseph J. Lowenthol, M.D. ..... Jacksonville
Jere W. Annis, M.D. ..... Lakeland
Herschel G. Cole, M.D. ..... Tompo
Wilson T. Sowder, M.D. ..... Jacksonville
Carlos P. Lamor, M.D. ..... Miami
Walter C. Poyne, M.D. ..... Pensacola

Manoging Editor
Stewart G. Thompson, D.P.H.
Ernest R. Gibson, Asst.

Committee on Publicotion
Shaler Richordson, M.D., Chairman ..... Jocksonville
Chas. J. Callins, M.D. ..... Orlando
James N. Potterson, M.D. ..... Tampa

Abstroct Deportment
Kenneth A. Morris, M.D., Chairmon ..... Jocksonville
Walter C. Jones, M.D. ..... Miami

Dr. Henry Perrine
Versatile Florida Pioneer

When the medical student studying under Dr. Henry Perrine entered their Ripley, Illinois office one evening in 1821 and found that the doctor had taken arsenic with the dose of Peruvian bark he usually took before being exposed to the night air, he was horrified. Carelessly, the student had left the poison in a measuring glass after experimenting with it, and the doctor had poured his medicine into that glass, in the dark, before drinking it. In great haste the student set out after the doctor and overtook him just as he was entering a patient's home a mile or so distant. Vigorous measures undoubtedly saved Dr. Perrine's life, but the incident marked a turning point in his career.

Born in New Brunswick, N. J., on April 5, 1797, a descendant of Daniel Perrin, a French Huguenot who settled in New Jersey in 1665, Henry Perrine had studied medicine in the office of the celebrated Dr. Dewers and at the age of 22 had sought his fortune in the West. A letter written by him on Nov. 15, 1819 from Ripley, Bond County, Illinois showed the fine spirit characteristic of the early American pioneer. Wrote the young doctor to his Uncle Henry:

> . . . Three years ago this county contained but fifteen families; it now has 3000 people. . . . I hope to spend my life [here]. . . .
>
> By all that's free and all that is desirable in freedom, I would rather endure the privations of this country for years, with the prospects I have before me, than to live in Jersey for the same time among comparative conveniences. . . .
>
> Not for a titled equipage
> Not for a slave attendant
> But for the glorious privilege
> Of living independent. . . .

Dr. Perrine did not, however, reckon with the effects of the accidental arsenic poisoning which almost cost him his life. He was confined to his bed for many weeks and later stated that he never fully regained his strength. On Jan. 8, 1822, soon after resuming his practice, he was married to Miss Ann Townsend. In March of the next year, Ann, the first of three children, was born. Not long afterward, his health became so impaired that he moved to Natchez, Miss., in search of a warmer climate. It was there in July 1824 that Hester, the second daughter, was born, and there he suffered a serious illness.

During the two years spent in Natchez, Dr. Perrine began treating malaria with large doses of quinine and hence shared with Dr. Thomas Fearn the honor of being the first to use adequate doses of the drug in treating the highly prevalent malarial fever. In 1826, there was published in The Philadelphia Journal of the Medical and Physical Sciences (4:36-41) an article by Dr. Perrine entitled "Fever Treated with Large Doses of Sulphate of Quinine, in Adams County, near Natchez,

ROYAL PALM AND BANYAN TREE ON THE PERRINE GRANT

THESE INTERESTING PHOTOGRAPHS WERE TAKEN ON THE PERRINE GRANT IN 1876.

Left, a young Royal Palm tree, with fern-like leaves and symmetrical trunk.

Below, a wide-spreading Banyan tree, hundreds of years old at the time the photograph was taken.

Miss." Based on Dr. Perrine's and Dr. Fearn's experiences, the therapy employed by surgeons during the Seminole War in Florida established the efficacy of using large doses of quinine in the treatment of malaria.

Finding that his health could not stand even the cold weather of Mississippi, "the talented little doctor" applied for a consulate in a tropical country. In January 1827 he was appointed United States consul at Campeche, Yucatan, Mexico.

During his ten year stay in Yucatan, he had an attack of both yellow fever and cholera and experienced another dramatic accident which again almost cost him his life. While visiting in the neighboring state of Tabasco, he was invited to attend the Governor's ball. Not having his consular uniform with him, he wore the usual garb of the country. As he leaned over the refreshment table to take a piece of fruit, a soldier standing guard nearby, without a word of warning, thrust his bayonet through his side. With blood flowing freely into his boot, Dr. Perrine stepped up to the Governor and quietly related what had happened. Drawing his sword, the Governor struck off the ear of the guard, ordered him to be imprisoned and summoned medical aid for Dr. Perrine. It is not known whether the valuable gold belts which the Governor presented to Dr. Perrine later were intended to compensate him in part for the accident or to give him recognition for his unusual services as a physician.

Dr. Perrine practiced gratuitously among the poor, and his medical services soon were in great demand. It was said that during a severe cholera epidemic in Yucatan his popularity as a physician became so great that crowds pressed toward him when he appeared, making it difficult for him to drive his carriage along the streets.

It was this popularity, however, which allowed Dr. Perrine to accomplish what no one else up to that time had been able to do. When the Secretary of the Treasury, under the direction of President John Quincy Adams, sent a circular to United States consuls in 1827, urging them to "introduce" into their homeland "all such trees and plants from other countries not hitherto known in the United States," Dr. Perrine appears to have been the only consul who took the directive seriously and attempted to follow instructions. His popularity among rich and poor alike later made it possible for him to secure the seeds of many tropical plants which prior to that time "the priesthood," it was said, had made it impossible to obtain; "or, if obtained, their vitality had been destroyed by having been soaked in boiling water."

In 1832, acting Florida Territorial Governor James Wescott in his message to the legislature stated:

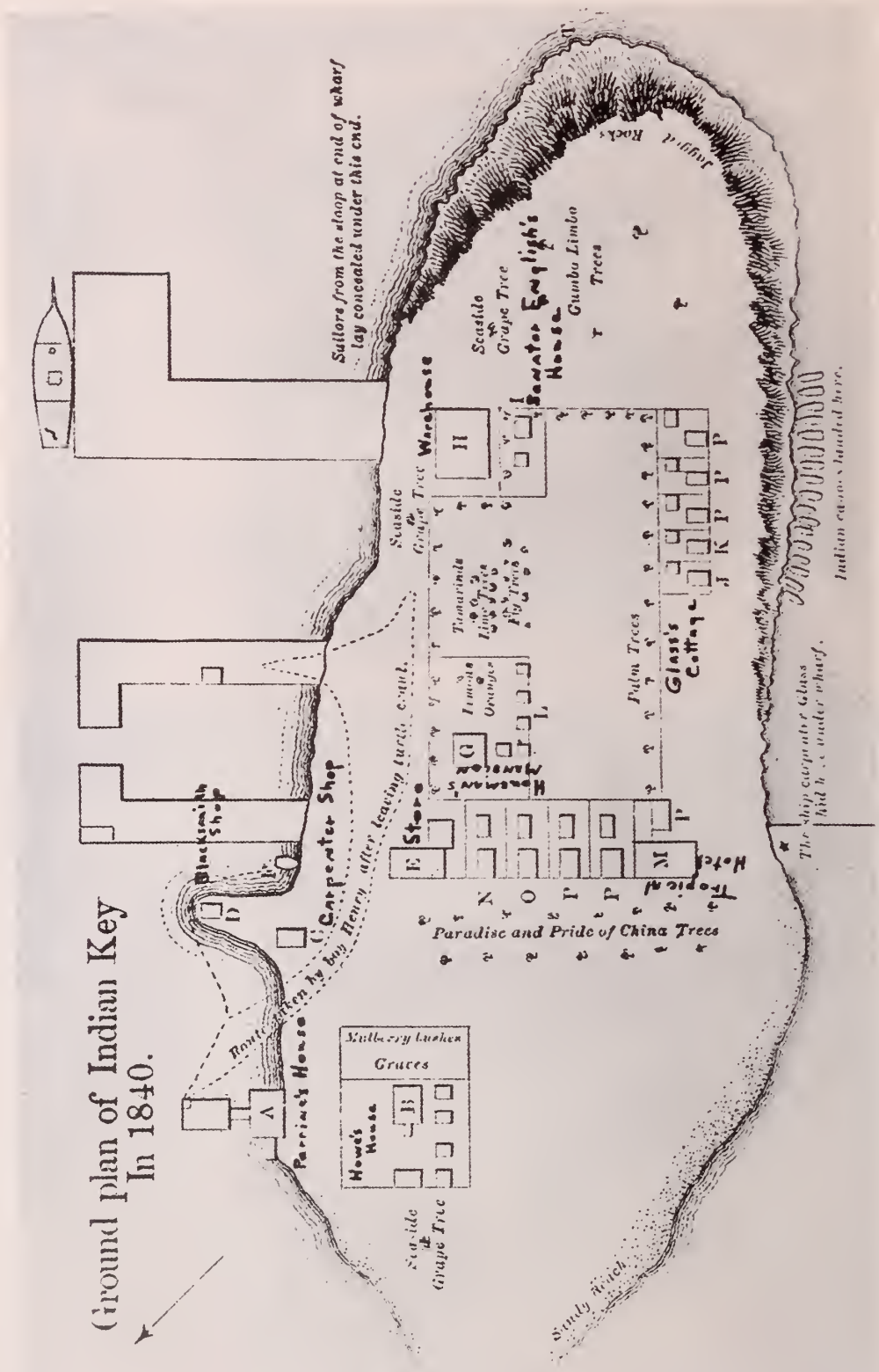
> I herewith transmit to the council. . .an extract of an official letter from H. Perrine, United States consul for Campeachy, to the Secretary of the Treasury. . . . Mr. Perrine is desirous that an act of the council should be passed incorporating himself and his associates into a company for the cultivation of tropical exotics, and he proposes to establish the plantation of the company on the southern part of the peninsula. This enterprise should not be classed with the inflated visionary projects of which Florida has been so prolific. . . . The benefits resulting to the country from the introduction of . . . many valuable foreign products . . . should induce us to render every encouragement and aid in our power to promote the success of the undertaking. . . . I earnestly recommend the granting of a charter as he wishes. . . . The tea plant, . . . the olive, ginger, pepper, cloves, cinnamon, pimento, nutmeg and cocoa . . . could, it is believed . . . be successfully cultivated in most parts of our Territory. If . . . we . . . have more formidable competition in the raising of cotton from Mexico, South America, the East Indies, from Egypt, and from the extensive countries bordering on the Black Sea . . . it is wise for the cotton planter to prepare for the adoption of other articles for cultivation. . . . Whether . . . cultivation of the cane, and the manufacture of sugar, can be relied upon as a certain source of profit to the Florida planter . . . is by many regarded as problematical; but . . . if the experiment fails immediately to yield the planter pecuniary profits, the arguments of . . . independence, and of patriotism, are still in favor of the adoption and culture of every useful exotic congenial to our soil and climate. . . .

The bill was passed by the Florida legislature later in 1832, but land in South Florida was not granted by the Congress until 1838. The official language of the grant is in part as follows:

> Be it enacted . . . that a township of land is hereby granted to Dr. Henry Perrine . . . in the southern extremity of the peninsula of East Fla. . . . one body of 6 mi. square. . . .
> Approved July 7, 1838.

The Perrine Grant is located a short distance south of Miami on Biscayne Bay. The present town of Perrine is located on the original site.

Upon his return to the United States in 1837, the year before the grant was made, Dr. Perrine was given much attention and was widely entertained. Several prominent residents urged him to establish a proposed nursery for useful tropical plants in Louisiana, and he was offered a portion of Lafitte's Island for that purpose. He had by that time, however, become thoroughly convinced that South Florida was the best place to establish a tropical reserve.


Ground plan of Indian Key
In 1840.
Sailors from the sloop at end of wharf lay concealed under this end.
Seaside Grape Tree
Warehouse
Senator English's House
Gumbo Limbo Trees
Rocks
Blacksmith Shop
Carpenter Shop
Store
Tamarinda
Lime Trees
Palm Trees
Glass's Cottage
Paradise and Pride of China Trees
Hospital
Mulberry bushes
Graces
Howel's House
Parrish's House
Boat taken by Billy Henry after leaving turtle crawl.
Sandy Beach

Dr. Perrine had already corresponded with Mr. Charles Howe, the postmaster and deputy inspector of Indian Key, Fla., and had sent him specimens of the stingless bees of Yucatan. Plants and seeds had been sent to a Captain Dubois at Cape Florida for experimentation. As early as 1833 Dr. Perrine had begun sending plants to a nursery on Indian Key.

Dr. Perrine's belief that the so-called worthless soil of a section in extreme South Florida would support a large population of small cultivators had been published and apparently discussed widely. After leaving New Orleans, the versatile doctor went to Key West, Fla., by way of Havana, Cuba, and on his way North stopped for a short time at Indian Key. He then went on to Washington to press his claims, after visiting his family in Palmyra, N. Y. En route, he was treated in Charleston, as earlier in New Orleans, as somewhat of a celebrity. From Baltimore on Nov. 6, 1837 he wrote his brother John:

> As my daughters have a taste for music I shall indulge them so far as to encourage their attempts at playing on the piano. I should, however, infinitely prefer that they become adept in drawing and painting, as auxiliaries to the natural sciences, especially to Botany. The drawing and painting of new plants in Tropical Florida will be pleasant and profitable pursuits for our daughters. . . . Painting may perpetuate their memories, and like writing, will enable them to transmit useful intelligence to distant places and future times.

The extent of his labors and the vast fund of information obtained by him as the result of his studies can be appreciated by reviewing the documents which he presented to the Congress. They were published in 1838 at the time of the passage of the Act granting him the township in South Florida.

In the meantime, the Seminole Indian War had begun, and the mainland was not safe for white inhabitants. Setting out with his wife, 11 year old son and two daughters in their early teens, Dr. Perrine arrived on Christmas Day of 1838 at Indian Key, about 30 miles from the mainland, where he believed they could live in safety until the end of the war would permit them to occupy and cultivate the tract on the mainland. This key was the home of the well known and somewhat notorious wrecker, Captain Jacob Housman, who had invested heavily on the 11 acre islet.

Dr. Perrine and his family lived on the tiny island for nearly two years, tending and extending the nurseries begun in 1833. They lived in a

Perrine house and ecsape tunnel to wharf.

two and a half story house topped by a cupola; its construction was soon to prove all important. There was a small wharf in front of the house. The foundation of the house was built in the water, and the cellar was in reality a bathing pool. Between the house and the wharf there was a connecting dark passageway about 15 or 20 feet in length and about 5 feet in width. Each side was built to the height of four feet with rock, upon which were laid heavy pieces of plank. Over the plank was a covering of rock and then plank again to connect with the wharf proper. This passageway appeared to be of solid masonry, as shown in the accompanying illustration.

In the early days of the Seminole War a small boat was kept in this place of concealment to provide a means of escape in case of attack by Indians at night. As time passed, however, all became lulled into fancied security, particularly in as much as the government had established a station for invalid soldiers on Tea Table Key, a small island about one and a half miles northeast of Indian Key. In 1840, the space under the wharf was being used as a turtle crawl.

Soon after midnight, on the morning of Aug. 7, 1840, members of the Perrine family were awakened by the savage cry of Indians who were approaching their house. Dr. Perrine helped his wife and three children escape through a trap door to steps which led down to the secret tunnel already described. He then called out to the savages, pleading with them and promising them medical assistance if they would stop pillaging and give up their apparent intent to kill and destroy. The family below then heard him retreat toward the upper part of the house and barricade himself in the cupola, the Indians in hot pursuit. There was great noise, then quiet, followed by sounds of

searching the first floor. When the house was finally burned, the doctor's bones were charred and his precious seeds and manuscripts were consumed. Mrs. Perrine and the three children, although nearly cooked, escaped almost miraculously in a boat while the Indians were drinking and pillaging a store nearby.

The doctor's remains were removed the next day by Henry, his son, and the village postmaster, who buried them on Lower Matecumbe Key under a huge sisal, in deference to his love for and intense interest in the species which he introduced.

This tragedy of 112 years ago, all but forgotten now, was news of widest interest at the time. Members of the family were given military escort North and everywhere were greeted with gifts and all forms of attention and sympathy. When their ship arrived in the harbor of St. Augustine, they were greeted by Dr. Peck, Dr. Anderson and Judge Gould, a delegation appointed by the citizens to meet them and tender them the hospitalities of the city. Rooms were placed at their disposal at The Florida House. Wrote Hester Perrine Walker years later:

> We had scarcely arrived when the parlor was filled with ladies and gentlemen, to offer their sympathy and help. When evening arrived, servants with baskets of clothing, began to arrive. . . .
>
> Gov. Reid, had left word, to "be sent for as soon as we arrived" and in the morning he with his beautiful young wife came in such state as became their position — carriage, footman, etc., to tender us the hospitality of their beautiful home.

Dr. Perrine is an excellent example of the courageous pioneer Florida physician who extended the scope of his interests beyond his profession. It is a matter of record that the Perrine Grant, consisting of 23,040 acres, was the first land grant ever made in this country to encourage agriculture. As land promoter and master of political acumen, the doctor won signal recognition from the Congress and might have advanced the development of South Florida by many years had he out-talked the Indians on the night of his massacre back in 1840. The century plants of that region today bear prolific testimony to him as the horticulturist who first introduced foreign tropical plants into the United States and as the botanist who first described the Agave sisalana.

Because of the tragic circumstances of his untimely death at the age of 43, he became to the Army an impelling reason for pressing the war against the Seminoles to a successful conclusion. Distinguished family connections make him important to the genealogist. To the Miamian he is the great-great-grandfather of former Mayor Perrine Palmer, Jr. Some Americans recognize him for his role in the founding of the Smithsonian Institution. But to his patients of more than a century ago he was "the little hard-riding ague doctor."

Unfortunately, there is no photograph extant of this great American whose energy, versatility, perseverance and faith in South Florida cost him his life in the region where some 56 years later Miami was founded. His unusual life story adds a noteworthy chapter to the annals of Florida medicine.

Good Reading for Americans

Whether in medicine, the other professions, business, industry, or any vocation or mode of life, it would appear that governmental red tape has an irksome hampering effect. The testimony of a distinguished business leader, given recently before the Senate Banking and Currency Committee relative to the proposed extension of the Defense Production Act, makes interesting reading to the medical profession. It should interest every citizen. Mr. William J. Grede, President of the National Association of Manufacturers, pleading for restoration of "the function of the free market," explained how controls hinder production and then added:

> Even when prices are below ceiling, which many are, the OPS compliance problem remains. The grind of administrative machinery is still there; the interpretative work of legal counsel is still there; the labors of great corps of accountants and clerks are still there; the time consuming job of analyzing regulations and making reports is still there; the particular situation of customers and suppliers is still there; prospects of new regulations with another new wave of interpretations, analyses, computations, surveys, studies, investigations, determinations, reports, protests and appeals are still there.
>
> These are the difficulties that are tangible, physical and measurable. As they boil and flame in the mind of management, their fusion creates a new substance which is psychological. Its effect is poisonous. It may be described as American psychology thrown in reverse. Confidence is turned into doubt; courage becomes fear, resourcefulness is replaced by caution; planning is turned into waiting; the taking of normal business risks gives way to a drawing-in of all commitments; the sense of freedom is thwarted by a feeling of imprisonment. The dynamic motivation which is the very essence of business progress is stifled.

This graphic portrayal of the governmental shackles hindering business also, as has been well

said, provides a plausible explanation for "the high coronary rate among industrial executives during these crazy times."

How did such times come about? Good reading for you, Doctor, for Mr. Grede, and for every American is Raymond Moley's new book, "How to Keep Our Liberty." Here are elucidated the dangers confronting this constitutional republic from statist attack. Here are traced the trends of the last 20 years, both politically and ideologically, which constitute an ever growing peril to our liberty. Here is presented "carefully reasoned and incontrovertible evidence of socialist thinking and motivation in the present administration's activities in medicine, industry, agriculture, banking, education and other areas."[1] Also, here are proposed positive answers to myriad problems confronting the nation and constructive measures for meeting them within the framework of traditional American liberties.

1. How to Keep Our Liberty: A Program for Political Action, Book Reviews, J. A. M. A. 148:778 (March 1) 1952.

The Changing Disease Pattern

It appears that inability to cope with emotional tensions induced by the strains of modern industrial and urban life is the reason "man has changed his disease pattern more in the last 50 years than in the previous 50,000." He has learned to protect himself against microbes. But has he learned to protect himself against himself? That he has not is evidenced by the fact that three out of the four principal causes of death today are strongly affected by mental and emotional stress.

Addressing a banquet meeting of the Florida Anti-Mosquito Association in Jacksonville recently, Dr. Frank G. Slaughter expressed this basic view of current health problems. He reminded his audience that half a century ago the leading causes of death were pneumonia and influenza, tuberculosis, and dysentery and enteritis. Today, heart disease, cancer and apoplexy take the lead, with accidents ranking fourth. Influenza and pneumonia now occupy fifth place, with other microbe-caused diseases showing similar declines.

In 1840, only 10 per cent of the population of this country was to be found in cities, but a century later, 56 per cent of the people were city dwellers. As society has become more industrial and urban, the greater have become the psychosomatic ills.

The resultant trend is away from individuality and toward the sacrifice of individual freedoms for the sake of security, Dr. Slaughter warned, and added wisely, "Man always pays for this security with loss of his health."

Antituberculosis Drugs

"Wonder drugs" appear to be getting commonplace. This time the information, seemingly prematurely released to the public, concerns antituberculosis drugs. Three isomers of niacin, produced under the trade names of Rimifon, Nydrazid and Marsilid, are said to be effective in the treatment of tuberculosis. These niacin derivatives, reportedly effective in vitro and animals, were used in the treatment of 190 patients "who had not responded to any of the present methods of treatment including . . . streptomycin and PAS . . . and for whom there was no hope . . .," according to an article in the New York Times.[1] Headlined as "Cheap Coal-Tar Synthetics," these new pharmaceuticals were heralded as perhaps reducing the "Cost of Whole Treatment . . . to $100 . . .," although "More Tests Held Necessary."

Both medically and from the viewpoint of cost of therapy, the implications of this news report and others less conservatively and factually written are exceedingly far reaching. It is, therefore, particularly important to keep in mind that even though these compounds may prove more effective and cheaper than any previous ones, reported clinical experience with them in the treatment of human beings is as yet small.

Dr. Henry C. Sweany, Chief Medical Director of the Florida State Tuberculosis Board, in this issue of The Journal explains why it is unfortunate that greater evidence of the clinical effectiveness of these drugs was not available at the time of public release of information about them. He also points out the error of assuming that the public and private institutions now maintained at great expense to combat tuberculosis will no longer be needed even though the new remedies prove to be true specifics against the disease. Nor in his opinion can the social problem presented by tuberculosis be solved so easily as by the advent of new and promising drug therapy.

It is well to keep in mind the impressive triumph for medicine, public health and public education already won in the battle to reduce mortality from this stubborn disease. In recently

published figures showing causes of death in 1951, tuberculosis ranks sixth in a series of six with 17.6 deaths per 100,000, in contrast to cardiac disease, which ranks first with 240.7 deaths. In 1900, tuberculosis ranked first in a series of 10 with 195 deaths, and in 1946 ranked seventh in a similar series.[1] It is hoped, of course, that release of the new compounds to physicians for use generally will bring even greater and more rapid progress.

We are, however, inclined to agree with our New York editorial colleague, who commented: "If nothing is as bad as it looks, it is also true that many things do not prove to be as good as they seem. We hope that jubilation will be confined to the narrow limits of the current small clinical evidence at hand. Northbrooke in 1577 observed that 'One swallowe prouveth not that summer is neare.'"

1. Antituberculosis Drugs, New York State J. Med. 52:1272 (May 15) 1952. New York Times, Feb. 22, 1952.

Periodic Physical Examinations Required

New federal regulations, effective July 1, 1952, raise the physical standards for truck, bus and taxicab drivers engaged in interstate commerce and require periodic physical examinations. In a general revision and tightening up of its safety code, the Interstate Commerce Commission announces the new requirements, which affect an estimated million or more drivers who come under its regulation.

The more important changes of interest to physicians include: 1. After Jan. 1, 1954, every driver must be physically re-examined at least once in three years; currently only a pre-employment physical examination is required. Both employer and employee must have the physician's certificate available at all times. 2. Visual acuity of not less than 20/40 in each eye (with glasses) will be required of new men, but drivers now on the job may qualify under the current standard until Jan. 1, 1954. (Current standard is 20/40 in one eye, 20/100 in the other.) 3. The present requirement of "adequate hearing" will be supplanted by a definite measurement of hearing, which must be met without dependence on a hearing aid.[1] Details may be obtained from the Interstate Commerce Commission, Washington, D. C.

1. Periodic Physical Examinations Required for Interstate Truck, Bus Drivers, Capitol Clinic 3:1 (May 19) 1952.

Pointed Testimony

Dr. Frank G. Dickinson, who directs the Bureau of Medical Economic Research of the American Medical Association, in his recent testimony in Washington before the President's Commission on the Health Needs of the Nation observed that "there has not been to date a realistic study which supports any valid claim that a national doctor shortage is pending." Among the many good points he brought out was this one: "Since people need everything, it can be safely assumed that there are unmet needs for medical services, legal services, dental services, Grade A milk, shoes, and any other goods or services which sell for a price. Since all needs are relative, it follows that all unmet needs are relative. Any approach to the study of regionalization will fail at the start if it is based upon the notion that unmet needs are absolute."

Pointing out that two estimates of the doctor shortage for 1960 have been made in recent years by the federal government, Dr. Dickinson stated that both "assumed a national shortage rather than bothering to prove a national shortage." Many factors, in his opinion, have been ignored in the two studies for making a reasonable estimate of the surplus or deficit in the 1960 supply of physicians.

"What do physicians do for people?" inquired this intrepid investigator. "What would more physicians do for people?"

"The median age of the dying has jumped from age 30 in 1900 to age 67. Volumes are being turned out currently on the social and medical care of the aged. Although a physician must always try as hard to prolong the life of an 80 year old man as he would to prolong the life of a 10 year old boy, the formulation of national policy on the need for physicians must seriously and sympathetically consider the increasing number and percentage of older people — products of medical progress."

1952 Medical District Meetings

"A", Panama City	October 27
"B", St. Petersburg	October 29
"C", Fort Pierce	October 30
"D", Daytona Beach	October 31

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bryson, E. Hampton, Coral Gables
Davis, Harold E., Miami
Gibboney, Harry S., Jr., Ocala
Goldstein, Samuel J., Miami Beach
Light, David S., Miami Beach
Wilber, Stewart A., Jacksonville

YOUR BLUE SHIELD

Doctor's Service Report

All information called for on the Doctor's Service Report is extremely important to the Blue Shield Plan. While some of the information may not appear to be pertinent to the particular case, it should be noted that the Doctor's Service Report serves several purposes.

The main purpose of the Doctor's Service Report is to provide a medium for reporting services rendered Blue Shield subscribers. Perhaps equally important is the statistical use to which the information is put. One of the most important items obtained from statistics is the charges made to the subscriber by the doctor. This allows the Plan to maintain records on the average charges for procedures and, where possible, revise the Schedule of Benefits accordingly.

Complete information on the Doctor's Service Report is necessary and insures prompt disposition of a Blue Shield claim whether or not the claim is to be paid or rejected. Reports that are incomplete require much time-consuming correspondence between the Plan and the physician causing a delay in the final action taken on the case. Immediate disposition of a case is desirable by the Plan and is of the essence to the physician. It goes without saying that the physician benefits by the prompt payment on a Blue Shield case, however, when a case must be disapproved by the Plan and the physician is promptly notified, he benefits by this action, insofar as he is notified in sufficient time to make other financial arrangements with the patient.

The Blue Shield physician can assure himself of prompt settlement on Blue Shield cases, either by the Plan or by the patient in cases where the Plan cannot extend its benefits, by the proper completion of the Doctor's Service Report.

Medical Officers Returned

Dr. John D. Bell, who entered military service in September, 1950, was released from active duty on Oct. 12, 1951, with the rank of Commander, MC, U. S. N. R. His address is 416 Blount Building, Pensacola.

Dr. George H. Anderson, who entered military service on Dec. 1, 1950, was released from active duty on May 2, 1952, with the rank of Captain, MC, USAFR. His address is 176 Fourth Avenue, N. E., St. Petersburg.

BIRTHS AND DEATHS

Births

Dr. and Mrs. J. Q. U. Thompson of Jacksonville announce the birth of a son, John Marcus, on April 5, 1952.

Dr. and Mrs. William H. Mathews of Jacksonville announce the birth of a son, Richard Guyton, on April 10, 1952.

Dr .and Mrs. Thomas Armour, Jr., of Coral Gables announce the birth of a son, Robert Harry, on April 28, 1952.

Dr. and Mrs. Ivan Isaacs of Jacksonville announce the birth of a daughter, Jane Ellen, on May 17, 1952.

Deaths — Members

Hopkins, William B., Tampa	April 27, 1952
Carefoot, George H., Fort Meade	May 3, 1952
Carter, George W., Chipley	May 5, 1952
Richardson, James C., Miami	May 5, 1952

Errata

Information in the June Journal listing the death of Dr. Robert L. Hughes of Bartow is in error.

The Editor Invites Your Contributions on Data of Notable Interest

STATE NEWS ITEMS

The Gulf Coast Clinical Society will hold its annual Scientific Meeting at the San Carlos Hotel in Pensacola, Oct. 16-17, 1952. Speakers scheduled on the program include Dr. Charles Mayo, Mayo Clinic; Dr. Charles Wilkinson, Professor and Chairman of the Department of Medicine, New York University Post Graduate Medical School; Dr. Charles P. Bailey, Charles P. Bailey Thoracic Clinic, Inc., Philadelphia; Dr. Keith Grimson, Professor of Surgery, Duke University, Durham, N. C.; and Dr. Louis T. Byars, St. Louis.

Dr. H. Marshall Taylor, President of the American Laryngological Association, presided over the Seventy-Third Annual Meeting of that organization in Toronto, Canada, on May 23 and 24. While in Toronto, he also attended the annual meetings of the American Laryngological, Rhinological and Otological Society and the American Otological Society.

The Florida Association of Blood Banks held its annual meeting in Orlando May 31-June 1. Dr. Horace A. Day, Orlando, past president, announced that the purpose of the meeting was the standardizing of operational procedure among Florida's 16 blood banks who are members of the association, and to present new developments of interest to the group.

Dr. Robert V. Artola of West Palm Beach spoke on "Noxious Agents Affecting the Nervous System" at a recent semi-monthly meeting of the Licensed Practical Nurses, Division 1.

Dr. Lorenzo L. Parks of Jacksonville, director of the Florida State Board of Health Bureau of Preventable Diseases and Chairman of the Florida Polio Planning Committee, spoke at the annual meeting of the Duval County Chapter, National Foundation for Infantile Paralysis in May.

Dr. Ernest J. Stevens of Orlando has returned to his practice after attending postgraduate courses at the Cook County Graduate School of Medicine in Chicago.

Schedule of the 1952 Medical District Meetings has been announced by Dr. Eugene G. Peek, Jr., Chairman of Council, as follows: "A", Panama City, October 27; "B", St. Petersburg, October 29; "C", Fort Pierce, October 30; and "D", Daytona Beach, October 31.

Dr. Gary E. Turner of Jacksonville was among a group who participated in a panel discussion on Boy-Girl Relationships at the first meeting of the Teen-Age Forum at the Riverside Baptist Church recently.

Dr. Ralph W. Jack of Miami was recently elected vice-president of the Continental Gynecologic Society at the meeting of the Society in New Orleans.

Among the speakers at the weekly basic science lecture program for surgical residents at the Veterans Hospital, Coral Gables, were Dr. Francis N. Cooke of Miami who spoke on "Traumatic Hemothorax," and Dr. John G. Chesney of Miami who spoke on "Carcinoma of the Esophagus."

Dr. Harrien W. Gray of Miami Beach announces the removal of his office to 541 Lincoln Road, suite 401, with practice limited to general surgery and gynecology.

Dr. Herbert Eichert of Miami was one of the speakers at the first Southeastern Heart Disease Control Seminar in Birmingham, Ala., on May 22.

Dr. Carlos P. Lamar of Miami spoke at the meeting of the Dade County Health Council on May 5. His subject was "Geriatrics."

Drs. Julian A. Rickles of Miami and D. Ward White and Herman Boughton of Miami Beach represented the Dade County Medical Association at a symposium on "Self-Examination of the Breast" at St. Francis' Hospital on May 7.

Dr. George F. Schmitt, Jr., of Miami spoke before a group of biology students at the Coral Gables High School recently on "Heart."

Drs. Eugene L. Jewett of Orlando and Ruth S. Jewett of Winter Park left recently for Madrid, Spain, where both gave papers at a meeting of the International College of Surgeons.

Dr. John W. Williams of Lakeland was moderator for a discussion of medical-legal problems held at Morrell Hospital in Lakeland recently. Taking part in the discussion were a group of Polk County lawyers and doctors. Speaking for the doctors were Drs. Edgar Watson, James R. West and Ralph B. Hanahan, all of Lakeland.

Dr. Allen E. Kuester of Cocoa spoke on socialized medicine at a recent meeting of the Kiwanis Club of Cocoa.

Drs. Turner E. Cato and Benjamin G. Oren of Miami spoke in favor of the sewage disposal bond issue before a Bayfront Park audience recently.

Dr. Frances E. M. Read of Jacksonville has resigned as director of the Bureau of Maternal and Child Health of the Florida State Board of Health.

Dr. Francis P. Cassidy of Pensacola spoke at a recent meeting of the Lions Club of that city. His subject was the many advancements in the field of medicine.

A three-day institute on the care of the premature infant was held in the Sellers Auditorium in Jacksonville in May. Among those taking part were Dr. Nathan Weil, Jr., who served as moderator for the round-table discussion on "First Twenty-four Hours of Premature Life," Dr. Camillus S. L'Engle who spoke on "Physiology and Medical Aspects of the Premature Infant," Dr. Luther W. Holloway who spoke on "Common Medical Problems of the Premature Infant," and Drs. E. Frank McCall and Max Suter.

Dr. Paul F. Wallace of St. Petersburg spoke before the Exchange Club of that city recently. He spoke on the need of a county medical examiner.

Dr. Jere W. Annis of Lakeland was chairman of the Polk County Guidance Center's annual fund campaign held during the month of May.

Dr. Thomas H. Lipscomb of Jacksonville has been re-elected representative director of the Duval County Tuberculosis Association on the Florida Tuberculosis Board.

Dr. Alpheus T. Kennedy of Pensacola was guest speaker at a recent luncheon meeting of the Kiwanis Club of Milton. He told the group of some of the symptoms and dangers of cancer and cited the progress that has been made in treating cancer in recent years.

Dr. Douglas R. Murphy of Venice spoke at a recent meeting of the Lower West Coast Blood Bank in Sarasota. His topic was "Recent Advances in Surgery."

Dr. Homer L. Pearson, Jr., addressed a recent meeting of the Woman's Auxiliary to the Dade County Medical Association on the Florida Medical Committee for Better Government.

Dr. James T. Cook of Marianna has been elected president of the Marianna Parent-Teacher Association.

Dr. Robert E. Blount of Fort Lauderdale was a recent guest speaker at a meeting of the Dania Woman's Club. Dr. Blount spoke and showed a film on cancer.

Dr. Richard C. Cumming of Ocala has been named Ocala's "outstanding citizen for 1951," by the Junior Chamber of Commerce.

Dr. Clarence M. Sharp of Jacksonville, Director of the Bureau of Tuberculosis Control of the State Board of Health, was the featured speaker at the third annual dinner of the Ochlockonee Tuberculosis and Health Association in Quincy in May.

Dr. Elwyn Evans of Orlando presented a paper on causes of chest pains and other symptoms that can be mistaken for a coronary heart attack at a meeting of the American College of Physicians in Cleveland recently.

Dr. Phillip W. Horn of Jacksonville was elected president of the Florida Trudeau Society at the Society's convention in Daytona Beach. Dr. Hawley W. Seiler of Tampa was elected vice-president.

Dr. S. Allen Clark of Lakeland was honored by friends and co-workers at a surprise buffet dinner on the occasion of his fiftieth anniversary in the practice of medicine.

Dr. G. Dekle Taylor of Jacksonville has been elected president of the Community Board of the Children's Speech Correction Clinic. He succeeds Dr. Hugh A. Carithers of Jacksonville.

Dr. William C. Roberts of Panama City addressed members of the Practical Nurses Association of Division 5 at a recent monthly meeting.

The new medical building of Dr. Arthur L. Hardie, Jr., of Jacksonville was recently dedicated to the memory of Dr. Robert B. Glenn, who with his wife was killed in in an airplane crash at Key West on April 25, 1951. The dedication took place just one year after the crash.

Dr. James C. Rinaman of St. Cloud spoke on "Mental Health" at a meeting of the St. Cloud Woman's Club recently.

Dr. Frederick J. Waas of Jacksonville spoke on the American Cancer Society's three-phase battle against the disease at a recent meeting of the Sons of the American Revolution.

Dr. Karl B. Hanson of Jacksonville has returned to his practice after taking a week's postgraduate course and attending clinics at Ann Arbor in April.

Dr. Sullivan G. Bedell of Jacksonville spoke on "Music Therapy" at the March luncheon meeting of the Friday Musicale Club of Jacksonville.

Dr. William J. Knauer, Jr., of Jacksonville gave a paper on "Single Medial Rectus Resection as an Initial Procedure for Estropia" at the Eleventh Clinical Meeting of the Wilmer Eye Institute in April.

Dr. James R. Sory of West Palm Beach and J. Champneys Taylor of Jacksonville attended the Fifth American Congress on Obstetrics and Gynecology at the Netherland Plaza Hotel in Cincinnati, March 31-April 4.

COMPONENT SOCIETY NOTES

Columbia

All members of the Columbia Medical Society have paid their state dues for 1952.

Dade

The Dade County Medical Association presented 21 of its past presidents with scrolls in recognition of their services in ceremonies at the Miami Woman's Club in March. Among those cited was Dr. John G. DuPuis, the only surviving charter member of the association and president of the group in 1907.

At the June meeting of the Association, two speakers from Alcoholics Anonymous gave a history of the organization and described their method of handling alcoholics.

Hillsborough

At the regular monthly meeting of the Hillsborough County Medical Association in May, the group voted to become a sustaining member of the Hillsborough County Crime Commission.

At the regular June meeting, Dr. Joseph C. Flynn of Tampa spoke on "Jaundice."

In April, Dr. Osborne A. Brines, professor of pathology at Wayne University College of Medicine in Detroit, addressed the medical staff of the Bay Pines Veterans Hospital and members of the Hillsborough County Medical Association and the Pinellas County Medical Society. His subject was "Cor Pulmonale."

Lake

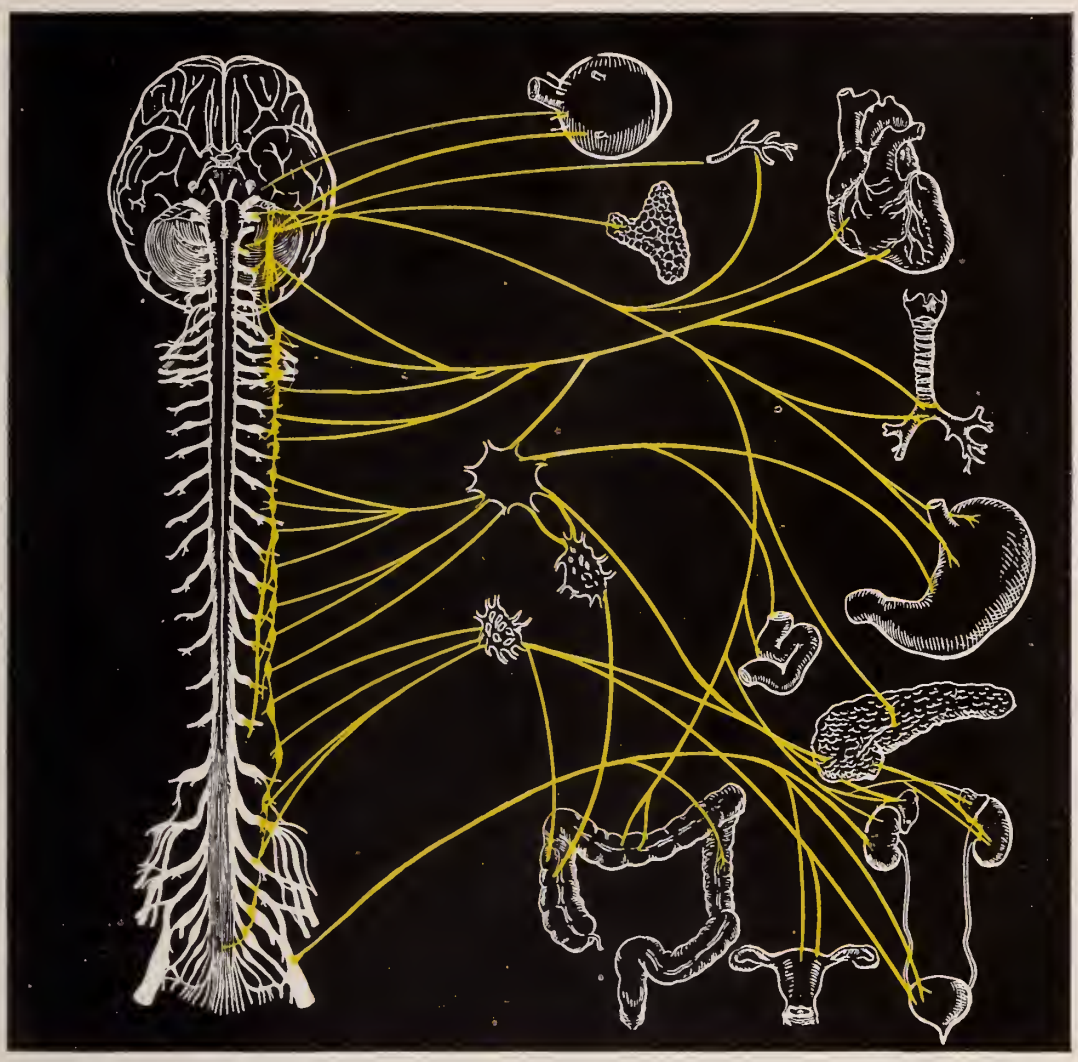
The Lake County Medical Society was host for the Crossroads Cancer Seminar on May 13. Medical societies of five counties were represented among the group attending the Seminar.

(Continued on page 58)

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

PHYSICIAN WANTED: Small central Florida town, near University, 30 miles from hospital. Living quarters available. Assistance in arrangement for office, fixtures, etc. considered for right man. Write: A. B. Rogers, Rogers Pharmacy, Trenton, Florida.



Excess neural stimulation over the parasympathetic subdivision plays an important role in such clinical conditions as peptic ulcer, certain forms of gastritis, pylorospasm, pancreatitis, spastic colon, bladder spasm and hyperhidrosis.

Banthine® Bromide (brand of methantheline bromide) is a true anticholinergic which inhibits parasympathetic stimuli, acting selectively on the gastrointestinal and genitourinary systems. It exerts little or no influence on the normal cardiovascular system. Banthine is supplied in oral and parenteral dosage forms.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

(Continued from page 56)

Marion

The regular monthly meeting of the Marion County Medical Society was held at the Elk's Club in Ocala on May 20. Several reports were heard, and Dr. Eugene G. Peek, Jr., reported on the meetings of the F. M. A. House of Delegates in Hollywood. It was announced that the next three monthly meetings will be held jointly with the staff of the Monroe Memorial Hospital. Twenty-nine members and their wives were present at this meeting.

Nassau

The Nassau County Medical Society at a recent meeting endorsed the multiphasic survey held in Nassau County, May 28-June 7. This survey presented screening tests covering four diseases of medical importance in Florida. It consisted of a chest X-ray and blood test, which were checked for possible tuberculosis, anemia, diabetes and syphilis.

Pinellas

Members of the Pinellas County Medical Society met with members of the Hillsborough County Medical Association and the Medical Staff of Bay Pines Veterans Hospital in April to hear Dr. Osborne A. Brines, professor of pathology at Wayne University School of Medicine, Detroit, speak on "Cor Pulmonale."

Dr. Chas. L. Farrington of St. Petersburg spoke at the regular June meeting of the society.

Ambulance Service

FERGUSON FUNERAL HOME
H. E. Ferguson, Licensed Director
1201 South Olive
WEST PALM BEACH, FLA.

BISCAYNE HOSPITAL
6339 Biscayne Blvd.
MIAMI 38, FLORIDA

Members of the Dade County Medical Association are acquainted with the high type of service rendered.

David Collins, Superintendent

Registered, American Medical Association
Phone 7-4544

OBITUARIES

John Randolph Perdue

Dr. John Randolph Perdue of Miami died at St. Francis Hospital in Miami Beach on March 27, 1952, after an illness of several weeks. He was 43 years of age. Interment took place in Rocky Mount, N. C., his former home where he was born in 1908.

Dr. Perdue was graduated from Randolph Macon College before receiving his medical training at the University of Virginia Department of Medicine, where he was awarded the degree of Doctor of Medicine in 1932. He then had special training in obstetrics and gynecology at Duke University School of Medicine.

In 1934, a year after his marriage to the former Dr. Jean Jones, a classmate at the University of Virginia, they came to Miami, where they practiced together with offices on Miami Beach. Dr. Perdue rapidly gained prominence as an outstanding practitioner and soon became one of the leading obstetricians of the area. During the 18 years that he practiced in the community, he labored tirelessly in the interests of his profession. At the time of his death, he was chief of staff in obstetrics at St. Francis Hospital and also served on the staff of several other hospitals. He was a life member and had been chairman of the board of directors of the Dade County Blood Bank, and was a member of the board of directors of the Dade County Cancer Institute. A member of the Miami Beach Rotary Club, he also held membership in the Bath Club, LaGorce Country Club and the First Presbyterian Church of Miami Beach.

Long active in the Dade County Medical Association, Dr. Perdue was also a member of the Florida Medical Association and the American Medical Association. He was a founder fellow and past president of the Miami Obstetrical and Gynecological Society, a founder member of the Florida Obstetric and Gynecologic Society, a founder member and past president of the South Atlantic Association of Obstetricians and Gynecologists, and president-elect of the section on obstetrics and gynecology of the Southern Medical Association.

He was also a member of the American Academy of Obstetrics and Gynecology and of the Southeastern Surgical Congress.

In addition to his widow, two children, Jean Duckett Perdue and Terry Randolph Perdue, both of Miami, survive him, and also his father, Randolph Perdue of Rocky Mount.

William Ross Thomson

Dr. William Ross Thomson of Miami Beach died in New York on March 17, 1952. He was 80 years of age. Interment took place in Warsaw, N. Y., his former home.

A native of Florida, Dr. Thomson was born in Pensacola in 1872. He received his medical education at the University of Virginia Department of Medicine and was awarded the degree of Doctor of Medicine in 1896. From 1898 to 1911 he was a member of the New York Medical Society and held the office of vice president in that organization. While he was practicing in Warsaw from 1911 to 1934, he was a member and at one time president of the Wyoming County Medical Society. He was for 20 years a member of the House of Delegates of the Medical Society of the State of New York, and served also as a member of its executive committee and as president of the Eighth District Branch.

In 1934, Dr. Thomson returned to his native state and engaged in the practice of medicine in Miami Beach, specializing in internal medicine. Previously, in New York, he had limited his practice to surgery, but owing to injury to his right arm in an automobile accident in which he was severely injured, he was obliged to discontinue the practice of surgery.

Dr. Thomson was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association. He was also a member of the American College of Surgeons.

Surviving is the widow, Mrs. Elizabeth V. Thomson of Miami.

Advertisement

From where I sit *by* Joe Marsh

Whitey Sure "Rang the Bell"

Telephone woke me out of a sound sleep last Friday night about eleven-thirty. "This is Whitey Fisher out on River Road," says a voice. "I just wanted to tell you how much I like this week's *Clarion*."

"Thanks, Whitey," I told him. "But why in blazes call to tell me at this time of night?" "Simple," he says, "your boy just delivered it a while ago. Been waiting for it all evening."

Next day, Buzzy Wilson tells me he delivered Whitey's paper late because he stayed for the school dance and thought it would be OK to drop it off on his way home.

From where I sit, I can't blame Whitey for his joke. He was just reminding me we owe other people the same respect we expect from them. Since I'm always talking about the other fellow's rights—like his right to enjoy a glass of beer and his right to practice his profession without interference, it was only fair that Whitey should "wake me up" to his *right to get his copy of the* Clarion *on time.*

Joe Marsh

Copyright, 1952, United States Brewers Foundation

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting August 4, August 18, September 8. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting September 8, October 20. Surgical Anatomy & Clinical Surgery, Two Weeks, starting September 22, November 3. Surgery of Colon & Rectum, One Week, starting September 15. Gallbladder Surgery, Ten Hours, starting October 20. Basic Principles in General Surgery, Two Weeks, starting September 8. General Surgery, Two Weeks, starting October 6. General Surgery, One Week, starting October 6. Breast & Thyroid Surgery, One Week, starting October 6. Esophageal Surgery, One Week, starting October 13. Thoracic Surgery, One Week, starting October 20. Fractures & Traumatic Surgery, Two Weeks, starting October 6.

GYNECOLOGY—Intensive Course, Two Weeks, starting September 8, October 20. Vaginal Approach to Pelvic Surgery, One Week, starting Septembr 22, November 3.

OBSTETRICS—Intensive Course, Two Weeks, starting September 29, November 3.

PEDIATRICS Informal Clinical Course every two weeks.

MEDICINE—Electrocardiography & Heart Disease, Two Weeks, starting July 14. Gastroscopy & Gastroenterology, Two Weeks, starting September 15, November 3.

UROLOGY Intensive Course, Two Weeks, starting September 8. Cystoscopy, Ten Days, starting every two weeks.

DERMATOLOGY—Intensive Course, Two Weeks, starting October 13.

Teaching Faculty:

Attending Staff of Cook County Hospital

Address: Registrar, 707 South Wood Street

Chicago 12, Illinois

MAC'S WALKERS

Made of light weight steel tubing (5lb.) Welded joints for strength and rigidity. Can't slip or turn. Safer than crutches. Stock sizes 32, 33, 34, 35, 36 inches. Give height of person when ordering. Children's and special sizes made to order. Price $11.00 delivered in Florida.

Made by

H. W. McCORD

2018 W. Fairbanks Avenue

WINTER PARK, FLORIDA

WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION

OFFICERS

MRS. HERSCHEL G. COLE, President.....*Tampa*
MRS. THOMAS C. KENASTON, President-elect.....*Cocoa*
MRS. RICHARD F. STOVER, 1st Vice Pres.....*Miami*
MRS. NELSON A. MURRAY, 2nd Vice Pres.....*Jacksonville*
MRS. REAVES A. WILSON, 3rd Vice Pres.....*Sarasota*
MRS. TAYLOR W. GRIFFIN, 4th Vice Pres.....*Quincy*
MRS. ALBERT G. LOVE, IV, Recording Sec'y.....*Gainesville*
MRS. HERBERT B. LOTT, Correspd. Sec'y.....*Tampa*
MRS. SAMUEL S. LOMBARDO, Treasurer.....*Jacksonville*

COMMITTEE CHAIRMEN

MRS. CHARLES F. HENLEY, Finance.....*Jacksonville*
MRS. EDWARD F. SHAVER, Today's Health.....*Tampa*
MRS. ALVIN L. MILLS, Legislation.....*St. Petersburg*
MRS. C. RUSSEL MORGAN, JR., Public Relations.....*Miami*
MRS. WILLIAM G. MERIWETHER, Reference.....*Plant City*
MRS. SHERREL D. PATTON, Civil Defense.....*Sarasota*
MRS. CARROLL V. HEPRON, Projects.....*Daytona Beach*
MRS. JULIUS ALEXANDER, Program.....*Miami*
MRS. JAMES T. COOK, JR., Bulletin.....*Marianna*
MRS. GEORGE H. PUTNAM, Historian.....*Gainesville*
MRS. ANGUS D. GRACE, Parliamentarian.....*Fort Myers*
MRS. ALFONSO P. MASSARO, Revisions.....*Tampa*
MRS. JOHN E. MAINES, JR., Stu. Loan Fund....*Gainesville*
MRS. ARTHUR R. KRAUF, Mediaux.....*Tampa*
MRS. CHARLES McD. HARRIS, JR., Study Groups.....*W. P. Beach*
MRS. C. ROBERT DEARMAS, Auxiliary Writer for State Medical Journal.....*Daytona Beach*
MRS. EDWARD W. CULLIPHER, S.H. Nurse Recruit. *Miami*
MRS. LEFFIE M. CARLTON, JR., Hospitality.....*Tampa*

Wagon Train

The annual convention of the Florida Medical Association and its Auxiliary at the Hollywood Beach Hotel was not only a success in every sense of the word relative to accomplishment and production, it was outstanding in that the heart of the operation didn't skip a beat in the shifting of executive authority and committee chairmanship.

There was no evidence of relief on the part of the outgoing leadership or reluctance on the part of the incoming leaders, but merely a shifting of positions and rearrangement of the team which is always a necessary expedient in an uphill climb when the cargo is valuable and the dangers ahead are known.

The convention was as gala as a circus. It had grandeur, color, gaiety, interest. The exhibits, the lectures and business meetings were contrasted pleasantly by outdoor frolic, music and entertainment. It was a great production which took skill, effort, initiative and time to produce. A tribute was paid to the many whose efforts oiled the machinery, provided the props and staged the setting for the annual performance of the Florida Medical Association achievements of the year.

Although the show is over, the work goes on. Maintenance crews are busy examining the construction of the vehicles which they must use to continue up the hill. Plans are being made for the distance they hope to cover and the route is being charted by which they plan to travel.

People are being chosen for their judgment and ability to further the advancement of this caravan of ideals. This requires discretion as well as delicacy for an organization is like a wagon train. The team must be nourished in proportion to the cargo it is expected to carry. Unless we use this grazing period afforded us by the summer inactivity to feed and digest the issues which surround us, it is futile to enlarge our organizational wagon capacity. For no matter how much we take on and hope to carry over the hill, if we are undernourished and inattentive we cannot deliver the goods.

Mrs. C. Robert DeArmas

BOOKS RECEIVED

Surgery and the Endocrine System, Physiologic Response to Surgical Trauma — Operative Management of Endocrine Dysfunction. By James D. Hardy, M.D., F.A.C.S. Pp. 153. Price, $5.00. Philadelphia, W. B. Saunders Company, 1952.

In this monograph, the author accomplishes well his twofold objective. First, he outlines the mechanisms by which the patient survives injury and clarifies for the general surgeon ways in which certain recent advances in physiology affect surgical care. In indicating the physiologic bases upon which intelligent management may enhance the capacity of the patient to withstand surgery, he recognizes the very considerable part which the endocrine organs play in mobilizing and transporting the metabolic reserves in an emergency.

Chapters 1 through 6 are devoted to a resume of the alarm response; the large influence which the hormones exercise in the regulation of the metabolism of body fluids and in shock; certain physiologic aspects of nutrition and ways in which the nutritional status of the patient may affect his capacity to withstand trauma; the physiologic consequences of prolonged bed rest and a rationale for early ambulation; the importance of endocrinology in the fields of infection, tissue repair and regeneration, and neoplasia; and endocrine therapy in surgical patients. In these fields, all of which are in their infancy, Dr. Hardy assembles all available material which can be accepted at this time and also presents excellent bibliographies.

His second objective is to present the facts and procedures he considers most useful in the management of surgical diseases of the endocrine organs. In bringing together those special problems which are of particular interest and importance to the general surgeon, he devotes chapters 7 through 11 to surgical problems related to the thyroid, parathyroids, pancreas, adrenals, pituitary, thymus, ovaries and testes.

This book covers a wide variety of subjects, many closely interrelated, and all of daily concern to the surgeon. It is not a handbook of preoperative and postoperative care. It is, however, a volume which provides the physiologic basis for many types of surgical therapy.

Annual Report on Stress. By Hans Selye, M.D., Ph.D. (Prague), D.Sc. (McGill), F.R.S. (Canada). Pp. 511 (133 R). Price, $10. Montreal, Canada, Acta, Inc., 1951.

This Annual Report on Stress is a treatise designed to fulfil the dual task of serving as a guide to the entire literature on stress and as a critical correlator of pertinent facts. It is presented as the first annual supplement to "Stress" ("Stress — The physiology and pathology of exposure to stress, a treatise based on the concept of the General-Adaptation-Syndrome and the Diseases of Adaptation" by Hans Selye, Acta, Inc., Medical Publishers, Montreal, Canada, 1950), but scrupulously avoids duplication of material already presented in that monograph. Each section, however, is written as a complement to the corresponding section of "Stress."

This volume, uniquely and conveniently arranged, sets the pattern for the Annual Reports on Stress in that it presents an extensive classified index of pertinent new facts and a concise textbook-like evaluation of the principal findings. It deals with some 3,000 references to articles almost all of which were published in the academic year immediately preceding publication.

This attempt at critical evaluation of newly acquired data and its prompt integration into the body of classical knowledge should greatly promote progress in this new subject which has already made impact upon almost every aspect of medicine. Within the comparatively short span of the last fifteen years, during which the stress concept has taken shape, and particularly during the last two years since ACTH and cortisone have become generally available, most physicians have decided to read up or experiment on some facet of this subject. Annual reports from the pen of Dr. Selye on the scale of this one should be most helpful in expediting this study.

Dynamic Psychiatry, Basic Principles. By Louis S. London, M.D. Pp. 98. Price, $2.00. New York, Corinthian Publications, Inc., 1952.

Designated Volume One, this book contains five chapters: The Evolution of Psychotherapeutics; The Meaning of the Dream; Psychology of the Libido; The Development of the Libido in the Child; and The Libido in the Adult.

After some fifteen years on the staffs of several of the largest mental hospitals in New York State, the author spent several years in intensive postgraduate study in neurology, psychiatry and psychoanalysis in Vienna. During the past twenty years he has been a consultant and engaged in private practice in New York City and Washington, D. C.

AVOID "OVERTREATMENT DERMATITIS"
"Overtreatment dermatitis is today a prevalent and often disabling cutaneous disturbance."*
* Lane, C. G., "Therapeutic Dermatitis", New Eng. J. Med., 246 77 81, 1952
AVEENO...the mild, soothing concentrate from oatmeal provides colloidal protection and emollient relief for irritated and itching skin areas . . . in colloid baths and in local applications.
Send for samples E. FOUGERA & CO., INC. • Distributors • 75 Varick St., New York 13, N. Y.

Doctor, be your own judge... try this simple test

With so many claims made in cigarette advertising, you, Doctor, no doubt prefer to judge for yourself. So won't you make this simple test?

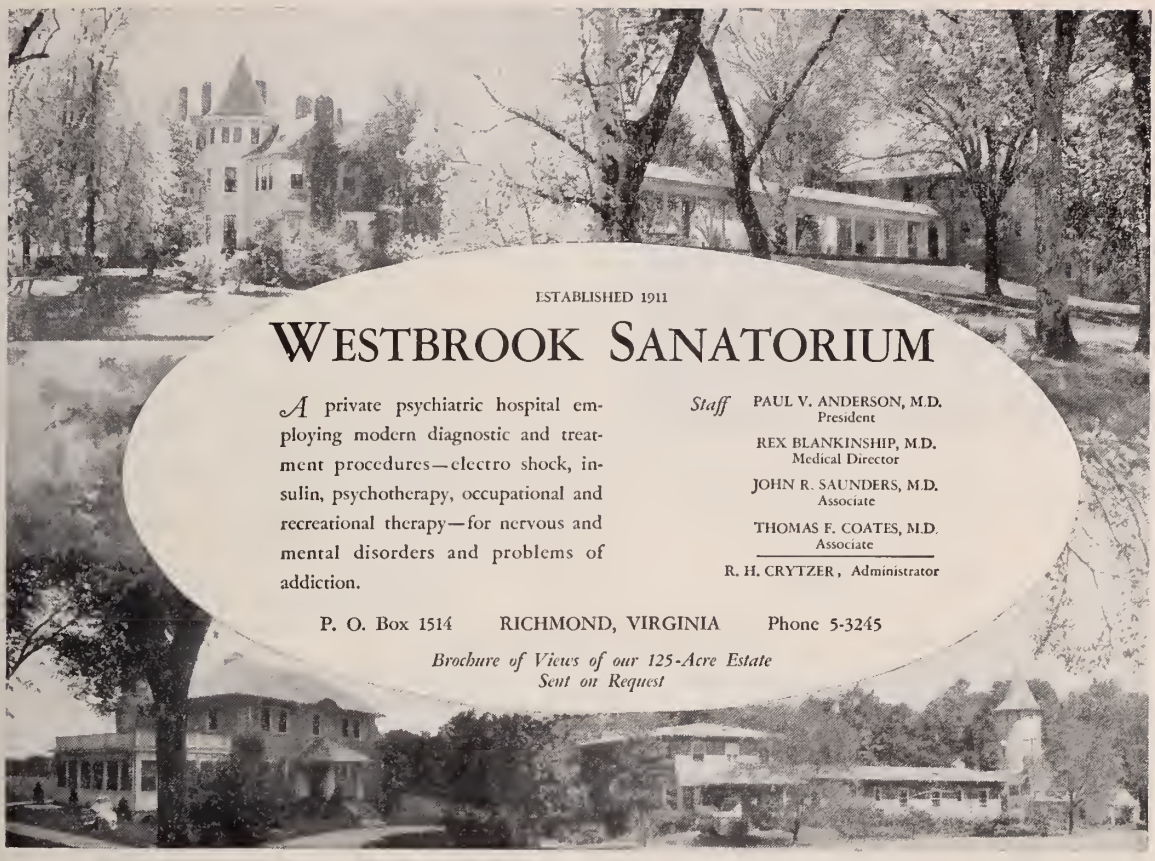
Take a PHILIP MORRIS and any other cigarette

1. Light up either one first. Take a puff—get a good mouthful of smoke—and s-l-o-w-l-y let the smoke come *directly* through your nose.
2. Now, do exactly the same thing with the other cigarette.

You will notice a distinct difference between PHILIP MORRIS and any other leading brand.

PHILIP MORRIS

Philip Morris & Co. Ltd., Inc., 100 Park Avenue, New York 17, N. Y.



ESTABLISHED 1911

WESTBROOK SANATORIUM

A private psychiatric hospital employing modern diagnostic and treatment procedures—electro shock, insulin, psychotherapy, occupational and recreational therapy—for nervous and mental disorders and problems of addiction.

Staff
PAUL V. ANDERSON, M.D.
President
REX BLANKINSHIP, M.D.
Medical Director
JOHN R. SAUNDERS, M.D.
Associate
THOMAS F. COATES, M.D.
Associate

R. H. CRYTZER, Administrator

P. O. Box 1514 RICHMOND, VIRGINIA Phone 5-3245

Brochure of Views of our 125-Acre Estate Sent on Request

MIAMI RETREAT SANATORIUM

FOUNDED 1927

For Nervous and Mental Disorders, Alcohol and Drug Addiction

STAFF OF EIGHT NEUROPSYCHIATRISTS
New X-Ray Diagnostic Treatment Facilities
Comfortable AIR-CONDITIONED rooms, suites

79TH STREET AT MIAMI AVENUE
MIAMI 38, FLORIDA

Phone 7-1824

S. A. Kyle

Funeral Director

MEMBER
National Selected Morticians
BY INVITATION

17 WEST UNION STREET
JACKSONVILLE 2, FLORIDA
Phones 5-3766 5-3767

THE EARLE JOHNSON SANATORIUM

For the care of nervous, mental, senile, alcoholic, and addicted cases.

MODERATE RATES

Write: Drawer 160 Telephone 33369

MERIDIAN, MISSISSIPPI

BRAWNER'S SANITARIUM

Established 1910

SMYRNA, GEORGIA
(Suburb of Atlanta)

For Nervous and Mental Disorders
Drug and Alcohol Addiction
Electro-Shock in selected cases

JAMES N. BRAWNER, M.D., Medical Director
ALBERT F. BRAWNER, M.D., Department for Men
JAMES N. BRAWNER, JR., M.D., Department for Women

Specialized
LABORATORY SERVICES

Thyroid Activity
determined by
SERUM PROTEIN-BOUND IODINE
a reliable index to presence and course of

Hypo and Hyper Thyroidism
now available routinely.
(12 cc. clotted blood required)

FLAME PHOTOMETRY
A safeguard against

ELECTROLYTE IMBALANCE
by most reliable, rapid instrument.

SODIUM, POTASSIUM AND CALCIUM TESTS
(1.0 cc. serum each test — 24 hrs. service)

URINE 17 KETOSTEROIDS TESTS
Available soon — Micro method 25 cc. required

Containers, instructions and rates on
request for physicians and hospitals.
Airmail — Special Delivery Suggested

Research Consulting

SHAW LABORATORIES
1923 14th Ave., So.
Birmingham, Alabama

Office Phone 4-4733 Night Phone 54-5960

Janet's Nursery for Babies
P. O. Box 191
OSPREY, FLORIDA
Phone RIngling 4-1647

A Nursery for Handicapped Babies

For Information write
H. KEITH JACOBUS
P. O. Box 191
Osprey, Florida

• In MIAMI
SANITARIUM

Medical Hospital American Plan Hotel for Patients and their families. REST, CONVALESCENCE, ACUTE and CHRONIC MEDICAL CASES. Elderly People and Invalids. *FREE Booklet!*

Acres Tropical Grounds, Delicious Meals,
Res. Physician, Grad. Nurses, Dietitian.

SUN-RAY PARK HEALTH RESORT

Mild Mental Cases,
Drug and Alcoholics
in Separate Building

The Right to *Choose* . . . .

CORNERSTONE OF AMERICAN LIBERTY

Hospital Expense Plans

Medical-Surgical Expense Plans

Paycheck Protection Plans

Life Insurance Plan

AS long as Americans keep the right to choose — their church, their political party, their doctor and their hospital — freedom must prevail.

We are proud that hundreds of thousands of Americans have freely chosen the protection afforded them by PENNSYLVANIA LIFE'S liberal, low-cost health insurance plan.

The Pennsylvania Life HEALTH & ACCIDENT Insurance Company

FOUNDED 1890

HOME OFFICE: PHILADELPHIA 5, PA.

19 District Offices in Florida

Miami	Executive Office 3028 Biscayne Blvd.	Fort Lauderdale	521½ South Andrews Avenue
	Downtown 1210 Pacific Building	Jacksonville	303 Clark Building
	Southwest 1260 S. W. 22nd Street	Tampa	228 Cass Street Arcade Building
	Little River 260 N. E. 79th Street, Rm. 3	Sarasota	237 Main Street, Room 15
	Coral Gables 3028 Biscayne Blvd.	Fort Pierce	Florida Bank Building, Room 34
	Miami Beach 3028 Biscayne Blvd.	Daytona Beach	116½ Orange Avenue
St. Petersburg	515 White Building	Tallahassee	429 Centennial Building
Lakeland	206 Marble Arcade	Panama City	142 Harrison Avenue
West Palm Beach	410 Datura Street	Pensacola	501 Theisen Building
Orlando	209 Slayton Building		

CONVENTION PRESS

218 WEST CHURCH STREET
JACKSONVILLE
FLORIDA

Commercial and
Publication
Printing

Allen's Invalid Home

MILLEDGEVILLE, GA.

Established 1890
For the treatment of
NERVOUS AND MENTAL DISEASES

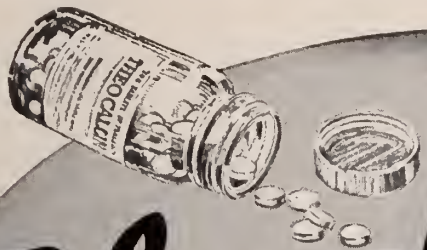
Grounds 600 Acres
Buildings Brick Fireproof
Comfortable Convenient
Site High and Healthful

E. W. ALLEN, M.D., *Department for Men*
H. D. ALLEN, M.D., *Department for Women*
Terms Reasonable

The Brook Haven Manor Sanitarium announces the opening of its annex for the reception of geriatric patients and the elderly.

Brook Haven Manor Sanitarium
Stone Mountain, Georgia

Suburb of Atlanta, Georgia



Theocalcin

For the Failing Heart of Middle Life

Prescribe 2 or 3 tablets of Theocalcin, t. i. d. After relief is obtained, continue with smaller doses to keep the patient comfortable. Theocalcin strengthens heart action, diminishes dyspnea and reduces edema.

Brand of theobromine-calcium salicylate,
Trade Mark reg. U. S. Pat. Off.

Bilhuber-Knoll Corp. Orange, N. J.

HILL CREST SANITARIUM

FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

Thoroughly modern in architecture and construction. Eight departments — affording proper classification of patients. All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

James A. Becton, M.D., Physician-in-charge — James Keene Ward, M.D., Associate Physician

P. O. Box 2896, Woodlawn Station, Birmingham, Alabama — **Phones 9-1151 and 9-1152**

TUCKER HOSPITAL, INC.

212 West Franklin Street

RICHMOND, VIRGINIA

A private hospital accepting for diagnosis and treatment organic neurological conditions, selected psychiatric and alcoholic cases, metabolic disturbances of an endocrine nature, individuals who are having difficulty with their personality adjustments, and children with behavior problems. Patients with general medical disorders admitted for treatment under our staff of visiting physicians.

Under the Professional Charge of

DR. HOWARD R. MASTERS,
DR. JAMES ASA SHIELD AND ASSOCIATES

HIGHLAND HOSPITAL, INC.

FOUNDED IN 1904

Asheville, North Carolina

AFFILIATED WITH DUKE UNIVERSITY

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a sixty-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D.,
Diplomate in Psychiatry
Medical Director

ROBT. L. CRAIG, M.D.,
Diplomate in Neurology and Psychiatry
Associate Director

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
da Medical Association	Robert B. McIver, Jacksonville	Samuel M. Day, Jacksonville	Hollywood, Apr. 26-29, '53
da Medical Districts	Eugene G. Peek, Jr., Ocala	Council Chairman	
-Northwest	Francis M. Watson, Marianna	Benjamin A. Wilkinson, Tallahassee	Panama City, Oct. 27, '52
-Northeast	William C. Thomas, Jr., Gainesville	Eugene L. Jewett, Orlando	Daytona Beach, Oct. 29, '52
-Southwest	Emmett E. Martin, Haines City	Hugh G. Reaves, Sarasota	St. Petersburg, Oct. 30, '52
-Southeast	Erasmus B. Hardee, Vero Beach	Donald W. Smith, Miami	Ft. Pierce, Oct. 31, '52
da Specialty Societies			
lemy of General Practice	Edward F. Shaver, Tampa	Frank T. Linz, Tampa	Hollywood, Apr. 26, '53
gy Society	Nelson Zivitz, Miami Beach	Solomon D. Klotz, Orlando	" "
thesiologists, Soc. of	John T. Stage, Jacksonville	Breckenridge W. Wing, Orlando	" "
›ter, Am. Coll. Chest Phys	Alexander Libow, Miami Beach	DeWitt C. Daughtry, Miami	" "
n. and Syph., Soc. of	Lewis Capland, Miami Beach	Morris Waisman, Tampa	" "
th Officers' Society	George W. Edwards, II, Orlando	Lorenzo L. Parks, Jacksonville	" "
strial & Railway Surgeons	Julius C. Davis, Quincy	John H. Mitchell, Jacksonville	" "
ology & Psychiatry	Samuel G. Hibbs, Tampa	William H. McCullagh, Jacksonville	" "
ınd Gynec. Society	Dorothy D. Brame, Orlando	J. Champneys Taylor, Jacksonville	" "
hal & Otol., Soc. of	Joseph W. Taylor, Sr., Tampa	Carl S. McLemore, Orlando	" "
opedic Society	Arthur H. Weiland, Coral Gables	Edward W. Cullipher, Miami	" "
ologists, Society of	Robert J. Poppiti, Miami Beach	Alfred E. Cronkite, Fort Lauderdale	" "
ıtric Society	Egbert V. Anderson, Pensacola	J. K. David, Jr., Jacksonville	" "
tologic Society	Alex. E. Rosenberg, Miami Bch.	George Williams, Jr., Miami	" "
ological Society	Thomas H. Lipscomb, Jacksonville	A. Judson Graves, Jacksonville	" "
ogical Society	George H. Putnam, Gainesville	David W. Goddard, Daytona Beach	" "
da—			
sic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	
ood Banks, Association	Horace A. Day, Orlando	Russell V. Douglas, Orlando	
ue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Daytona Beach, Nov. 16, '52
ue Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 26, '53
ncer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	
ental Society, State	W. G. McLeod, D.D.S., Pensacola	Coleman Brown, D.D.S., Tampa	St. Petersburg, Apr. 20-23, '53
art Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
›spital Association	Mother Loretto Mary, Tampa	Tracy B. Hare, Miami	Daytona Beach, Nov. '52
edical Examining Board	Bricey M. Rhodes, Tallahassee	Homer L. Pearson, Jr., Miami	
edical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
ırses Association, State	Miss Undine Sams, Miami	Bertha King, Tampa	St. Petersburg, Nov. 14-16, '52
ıarmaceutical Association, State	Mr. Clyde Morris, Daytona Beach	Mr. R. Q. Richards, Ft. Myers	St. Petersburg, May, '53
ıblic Health Association	Mrs. May Pynchon, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Jacksonville, Oct., '52
ıberculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Elsa B. Conant, Pt. St. Joe	
oman's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	Hollywood, Apr. 26-28, '53
rican Medical Association	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	
M.A. Clinical Session	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	Denver, Dec. 2-5, '52
hern Medical Association	R. J. Wilkinson, Huntington, W. Va	Mr. C. P. Loranz, Birmingham	Miami, Nov. 10-13, '52
ama Medical Association	B. W. McNease, Fayette	Douglas L. Cannon, Montgomery	Birmingham, Apr. 16-18, '53
gia, Medical Assn. of	C. F. Holton, Savannah	Mr. Sid Wrightsman, Atlanta	Savannah, May 10-13, '53
Hospital Conference	Mr. Norman Losh, Orlando	Mr. D. O. McClusky, Tuscal'sa, Ala.	New Orleans, April 8-10, '53
heastern Allergy Assn.	Clarence Thomas, Nashville, Tenn.	Kath. B. MacInnis, Columbia, S. C.	
heastern, Am. Urological Assn.	William Miner, Covington, Ky.	Sidney Smith, Raleigh, N. C.	Havana, Cuba, Mar. 26-29, '53
heastern Surgical Congress	H. L. Claud, Washington, D. C.	B. T. Beasley, Atlanta	Louisville, Mar. 9-12, '53
Coast Clinical Society	Alvin L. Stebbins, Pensacola	Dale E. York, Pensacola	Pensacola, Oct. 16-17, '52

MIAMI MEDICAL CENTER

P. L. DODGE, M.D.
Medical Director and President

1861 N. W. South River Drive
Phones 2-0243 — 9-1448

A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures — Psychotherapy, Insulin, Electroshock, Hydrotherapy, Diathermy and Physiotherapy when indicated. Adequate facilities for recreation and out-door activities. Cruising and fishing trips on hospital yacht.

Information on request
Member American Hospital Association

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS Total	MEMBERS Paid	COUNCIL
A	Bay	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	William F. Humphreys, Jr., M.D. 112 E. 3rd Court Panama City		24	21	
	Escambia **Santa Rosa*	Chas. J. Heinberg, M.D. 109 N. Baylen St. Pensacola	Raymond B. Squires, M.D. 386 Brent Bldg. Pensacola	2nd Tuesday 8:00 P.M.	75	70	
	Franklin-Gulf	John W. Hendrix, M.D. Port St. Joe	William P. Blackmon, M.D. Apalachicola	Last Wednesday	8	7	A-1-54 Francis M Watson, M. Marianna
	Jackson-Calhoun	Albert E. McQuagge, M.D. 207 N. Green St. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	15	
	Walton Okaloosa	William D. Cawthon, M.D. DeFuniak Springs	Edgar H. Myers, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	15	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		5	100%	
	Columbia **Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	100%	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	Ernest W. Ekermeyer, M.D. 516 N. Adams St. Tallahassee	George H. Massey, M.D. 204 N. Madison St. Quincy	Quarterly 7:30 P.M.	58	53	
	Suwannee	Edward G. Haskell, Jr., M.D. Branford	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak	1st Saturday 9:30 A.M.	9	100%	A-2-53 Benjamin A Wilkinson, M Tallahassee
	Madison	A. Franklin Harrison, M.D. Madison	Eugene D. Thorpe, M.D. Madison		3	100%	
	Taylor **Dixie, Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	1	233
B	Alachua **Bradford, Gilchrist, Union*	Henry J. Babers, Jr., M.D. Box 709 Gainesville	Raymond S. Camp, M.D. 907 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	49	48	
	Duval **Clay*	Ferdinand Richards, M.D. 508 Greenleaf Bldg. Jacksonville	Joseph A. J. Farrington, M.D. 415 Greenleaf Bldg. Jacksonville	1st Tuesday 8:15 P.M.	254	228	
	Marion **Levy*	Carl S. Lytle, M.D. 1206 E. Ocklawaha Ave. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	30	26	B-3-54 William C. Thomas, Jr., M Gainesville
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	10	9	
	Putnam	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	Bennie J. Massey, M.D. Box 105 Palatka	2nd Tuesday 6:00 P.M.	11	10	
	St. Johns	Charles C. Grace, M.D. 145 King St. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
	Brevard	James A. Sewell, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	23	21	
	Lake **Sumter*	Robert H. Montgomery, M.D. Mount Dora	J. Basil Hall, M.D. Mount Dora	1st Wednesday 7:30 P.M.	26	25	B-4-53 Eugene L. Jewett, Orlando
	Orange **Osceola*	Carl S. McLemore, M.D. 1217 Kuhl Ave. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	153	141	
	Seminole	Julian N. Tolar, M.D. First Street Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	16	100%	
	Volusia **Flagler*	J. Richard West, M.D. 224 S. Palmetto Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	80	79	667
C	Hillsborough	Sherman B. Forbes, M.D. 409 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	173	153	
	Manatee	John E. Granade, M.D. 114 Walcaid Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	19	16	
	Pasco-Hernando- Citrus	William H. Walters, Jr., M.D. Lacoochee	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	17	16	C-5-53 Hugh G. Reaves, M Sarasota
	Pinellas	John P. Rowell, M.D. 2500 Driftwood Rd., S. E. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Monday 6:30 P.M.	191	186	
	Sarasota	Henry G. Morton, M.D. 555 Golf St. Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	2nd Tuesday 8:30 P.M.	44	100%	
	DeSoto-Hardee- Highlands- Glades	Harold S. Agnew, M.D. 705 E. Oak St. Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	26	23	
	Lee-Charlotte- Collier-Hendry	John S. Stewart, M.D. Lee Memorial Hosp. Fort Myers	Harvie J. Stipe, M.D. 210 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	24	23	C-6-54 Emmett E. Martin, M.D. Haines City
	Polk	Ivan W. Gessler, M.D. 402 Professional Bldg. Winter Haven	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	90	82	584
D	Indian River	P. T. McClellan, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	6	
	Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Drive West Palm Beach	David A. Newman, M.D. 511 Citizens Bldg. West Palm Beach	3rd Monday 8:00 P.M.	117	115	D-7-54 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie- Okeechobee- Martin	Richard F. Sinnott, M.D. 209 Koblegard Bldg. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	15	12	
	Broward	Lloyd U. Lumpkin, M.D. 918 E. Las Olas Blvd. Ft. Lauderdale	William K. Peck, M.D. 915 N. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	82	72	
	Dade	Ralph S. Sappenfield, M.D. 630 duPont Bldg. Miami	Nelson Zivitz, M.D. 311 Lincoln Rd. Miami Beach	1st Tuesday 8:30 P.M.	602	524	D-8-53 Donald W. Smith, M. Miami
	Monroe	James B. Parramore, M.D. Box 326 Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	13	12	836

WHAT'S NEW? ---

TRIMAR

(TRICHLOROETHYLENE, U.S.P.)

FOR ANALGESIA AND ANESTHESIA

MAY BE ADMINISTERED WITH A HEIDBRINK GAS MACHINE FOR SURGERY AS AN ADJUNCT TO NITROUS OXIDE OR USED WITH THE APPARATUS ILLUSTRATED TO INDUCE AND MAINTAIN ANALGESIA IN OBSTETRICS, MINOR SURGERY AND OTHER PAINFUL CONDITIONS AS FOUND IN HOSPITAL OUT-PATIENTS.

TRIMAR IS

NON-EXPLOSIVE

NON-INFLAMMABLE

NON-TOXIC IF ADMINISTERED ACCORDING TO DIRECTIONS

USEFUL ON INFANTS AND CHILDREN

USUALLY NOT NAUSEATING

MEMBER

AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A. Quality and Service

Anderson Surgical Supply Co.

Established 1916

Telephone 5-8391
40-42 W. DUVAL STREET
P. O. Box 1799
JACKSONVILLE 1, FLORIDA

Telephone 2-8504
1101-1105 TAMPA STREET
P. O. Box 1228
TAMPA 1, FLORIDA

Telephone 7-4589
21 3rd STREET N.
ST. PETERSBURG, FLORIDA

NEW YORK ACADEMY OF MEDICINE
2 E 103RD ST
NEW YORK N Y 29

LACTUM

Mead's liquid formula made from whole milk and Dextri-Maltose

AS NUTRITIONALLY SOUND...

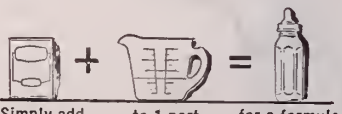
The generous milk protein content of Lactum provides for sturdy growth and sound tissue structure. Dextri-Maltose® supplements the lactose of the milk so that energy needs may be met, fat properly metabolized, and protein spared for its essential functions.

For more than 40 years, milk and Dextri-Maltose formulas with the approximate proportions of Lactum have been used with consistent clinical success. Infants fed Lactum* show good tolerance of feedings, low incidence of digestive disturbances and infections, satisfactory growth response and a generally excellent picture of health and development.

*Frost, L. H., and Jackson, R. L.: J. Pediat., 39:585-592 (Nov.) 1951

AS IT IS CONVENIENT

Mothers appreciate the ease of Lactum's simple 1:1 dilution. It assures accurate measurement. Lactum is ideal also for supplementary and complementary feedings, and whenever single feedings are indicated.



Simply add 1 part Lactum... to 1 part water... for a formula supplying 20 calories per fluid ounce.

MEAD'S

MEAD JOHNSON & COMPANY
EVANSVILLE 21, IND., U. S. A.

The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXIX AUGUST, 1952 No. 2

IN THIS ISSUE

Management of Acute Cholecystitis
William J. Clifford and Harold W. Keschner

Accidents Among Florida Children
Hugh A. Carithers

Thrombotic Thrombocytopenic Purpura
Nathan L. Marcus

The Hypertension Pendulum
An Editorial

OFFICIAL PUBLICATION OF THE
FLORIDA MEDICAL ASSOCIATION

In hay fever

BENADRYL (diphenhydramine hydrochloride, Parke-Davis) gives rapid—and sustained—relief to patients distressed by hay fever symptoms. By alleviating sneezing, nasal discharge, lacrimation, and itching, this outstanding antihistaminic has enabled many thousands of patients to pass hay fever seasons in comfort.

BENADRYL'S reputation stems from its *clinical performance.* Each year, as the pollen count rises, the benefits derived from this effective antihistaminic are further emphasized. BENADRYL Hydrochloride is available in a variety of forms—including Kapseals®, 50 mg. each; Capsules, 25 mg. each; Elixir, 10 mg. per teaspoonful; and Steri-Vials®, 10 mg. per cc. for parenteral therapy.

BENADRYL®

for a symptom-free season

MEDICAMENTA VERA

Parke, Davis & Company

DETROIT, MICHIGAN

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

Volume XXXIX AUGUST, 1952 No. 2

CONTENTS

SCIENTIFIC ARTICLES

The Management of Acute Cholecystitis, William J. Clifford, M.D., and Harold W. Keschner, M.D. 91

Accidents Among Florida Children Leading Cause of Death, Hugh A. Carithers, M.D. 97

Thrombotic Thrombocytopenic Purpura, Nathan L. Marcus, M.D. 101

ABSTRACTS OF MEDICAL ARTICLES

Drs. M. M. Coplan, Frank M. Woods, P. D. Melvin and J. K. David, Jr. 107

EDITORIALS AND COMMENTARIES

The Hypertension Pendulum 111

Medical Men and Medical Events in Early St. Augustine 112

Road Slaughter 117

Side Entrance Technic 118

Posthumous Award to Howard Blakeslee 119

A. M. A. Convention Big and Busy 119

GENERAL FEATURES

Officers and Committees 108

From Our President 110

Births and Deaths 121

State News Items 121

Wanted — For Sale 123

Component Society Notes 123

Obituaries 124

Woman's Auxiliary 126

Books Received 128

Schedule of Meetings 137

List of County Medical Societies, Presidents and Secretaries 138

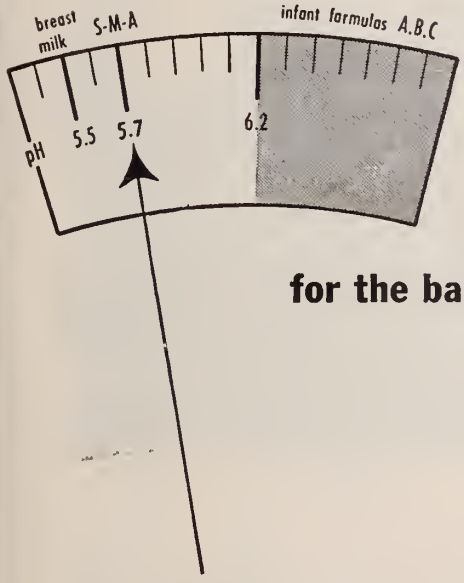
This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

clinical tests prove S-M-A®

is the only infant feeding formula that

- establishes a predominantly gram-positive flora—similar to the flora of the lower intestine of the breast-fed baby.[1]



- produces a stool with a pH "practically identical" with that of the infant fed human milk. Stools of babies fed other formulas are distinctly more alkaline (6.2 to 6.7).[1]

for the baby S-M-A means:

1 *Better absorption of minerals, especially calcium.*

2 *Lower incidence of constipation.* Formation of calcium soaps is inhibited; acid produced by fermentation stimulates peristalsis.

3 *Lessened susceptibility to diarrhea.* Lactobacilli inhibit overgrowth of 'colon' group bacilli.

4 *A stool typical of the breast-fed infant*—having a "buttermilk-like", rather than putrefactive odor.

5 *Vitamins more readily available, especially vitamin B_{12}.* Growth of putrefactive organisms which reduce amounts of vitamins available[2] is inhibited.

6 *Minimal danger of perianal dermatitis and diaper rash in the new-born.*[3]

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

REFERENCES

1. Barbero, G.J., Runge, G., Fischer, D., Crawford, M.N., Torres, F. E., and Gyorgy, P.: J. Pediat. *40*:152 (Feb.) 1952.
2. Watson, J.: Gordon Research Conf. Vitamins and Metabolism, 1950.
3. Torres, F.E., Romans, I.B., and Wheller, J.B.: A Study of Infantile Diaper Rash. To be published.

Wyeth®

"therapeutic bile" overcomes stasis

what is "therapeutic bile"?

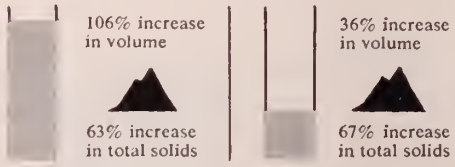
Thin, free-flowing bile in copious amounts as produced by *hydro*choleresis with *Decholin*.

what does "therapeutic bile" do?

Overcomes stasis in chronic cholecystitis and noncalculous cholangitis by flushing thickened bile, mucus plugs and debris from the biliary tract.

how does "therapeutic bile" differ from other bile?

"THERAPEUTIC BILE" is higher in fluid content and lower in solid content than bile produced by choleretics, e.g., ox bile salts.



*Hydro*choleretic: *Decholin*

Choleretic: Ox bile salts

DECHOLIN®
(brand of dehydrocholic acid)

how is "therapeutic bile" obtained?

"THERAPEUTIC BILE" is obtained by adequate dosage of *Decholin* and *Decholin Sodium*. Most patients require one or two tablets t.i.d. for four to six weeks. Prescription of 100 tablets is recommended for maximum efficacy and economy. More prompt and intensive *hydro*choleresis may be achieved by initiating therapy with *Decholin Sodium* 5 cc. to 10 cc. intravenously, once daily.

Decholin Tablets, 3¾ gr. (0.25 Gm.), bottles of 100, 500, 1000 and 5000.

Decholin Sodium (brand of sodium dehydrocholate) 20% aqueous solution, ampuls of 3 cc., 5 cc. and 10 cc.

AMES COMPANY, INC.

ELKHART, INDIANA

Ames Company of Canada, Ltd., Toronto

D-1

"PREMARIN"®

Highly effective • Well tolerated • Imparts a feeling of well-being

"PREMARIN"

Thousands of physicians prefer "Premarin" for the treatment of the menopause.

"PREMARIN"

Estrogenic Substances (water-soluble)

"PREMARIN"

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

also known as Conjugated Estrogens (equine)

"PREMARIN"

5210

Ayerst®

AYERST, McKENNA & HARRISON Limited • New York, N. Y. • Montreal, Canada

IN FALL ALLERGIES . . .

Turn Distress

into Comfort

Time-tested therapy with NEO-ANTERGAN* turns malaise into comfort for patients suffering from ragweed pollens.

Neo-Antergan brings safe symptomatic relief quickly by effectively blocking the histamine receptors.

Promoted exclusively to the profession, Neo-Antergan is available only on your prescription.

Your local pharmacy stocks Neo-Antergan Maleate *in 25 and 50 mg. coated tablets in bottles of 100, 500, and 1,000.*

The Physician's Product

Neo-Antergan®

MALEATE
(PYRILAMINE MALEATE, MERCK)

COUNCIL ACCEPTED

Research and Production for the Nation's Health

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY

© 1952—Merck & Co., Inc.

Chronic asthmatic

BACK SERVING WITH A SMILE

No need for the chronic asthmatic to give up work, play, a normal life. With NORISODRINE Sulfate, a quick-acting bronchodilating powder, symptomatic relief is as near as the patient's pocket or purse.

When the asthmatic feels an attack coming on, he simply takes three or four inhalations of the powder, using the pocket-sized AEROHALOR. Result? The bronchospasm usually ends quickly. No injections, no cumbersome equipment, no need to leave the job.

NORISODRINE is effective against both mild and severe asthma.[1,2,3] It has relatively low toxicity, and with proper administration, side-effects are few and usually minor. Before prescribing NORISODRINE, however, the physician should familiarize himself with administration, dosage and precautions. Literature may be obtained by writing Abbott Laboratories, North Chicago, Illinois. Abbott

EASY TO CARRY
IN POCKET OR PURSE

NORISODRINE®

SULFATE POWDER

(ISOPROPYLARTERENOL SULFATE, ABBOTT)

for use with the AEROHALOR® Abbott's Powder Inhaler

1. Kaufman, R., and Farmer, L. (1951), Norisodrine by Aerohalor in Asthma, Ann. Allergy, 9:89, January-February. 2. Swartz, H. (1950), Norisodrine Sulphate (25 Per Cent) Dust Inhalation in Severe Asthma, Ann. Allergy, 8:488, July-August. 3. Krasno, L., Grossman, M., and Ivy, A. (1949), The Inhalation of 1-(3',4'-Dihydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust), J. Allergy, 20:111, March.

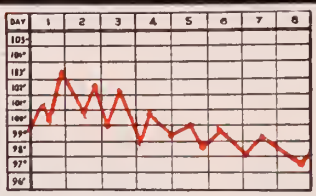
URINARY TRACT

Pyelonephritis

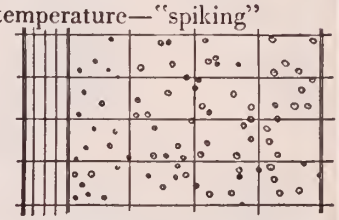
1 Pyelonephritis occurs most often in the young child . . .

commonest in the "diaper age" female

2 The onset is sudden, usually with a chill . . .



. . . temperature—"spiking"



. . . white cell count—high

3 Always, pus cells and bact pear in the urine

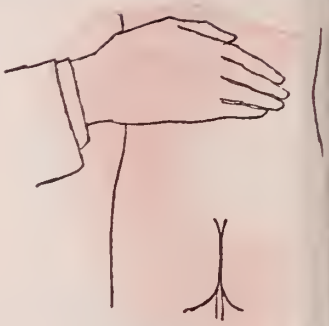
look for *clumps* of white cel in *catheterized* specimens

4 Culture determines pathogen. Mixed infection not uncommon.

in 8 out of 10 children, colon bacillus invades

5 Sometimes there is tenderness over the kidney region . . .

try the McKnight punch, or

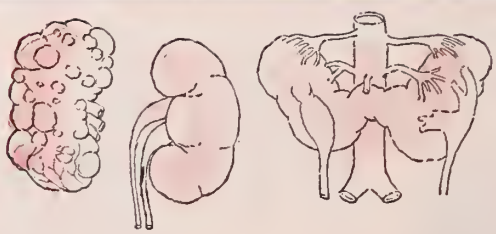


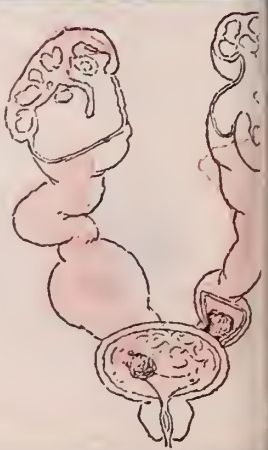
palpation in C-V an

6 . . . or abdominal pain and rigidity

suggestive of an acute abdomen

7 Look for a cause of urinary stasis.





in children, 75% have congenital malformation . . . others may have calculus, foreign body, neoplasm, ureteral spasm.

FECTIONS

CRYSTALLINE

Terramycin

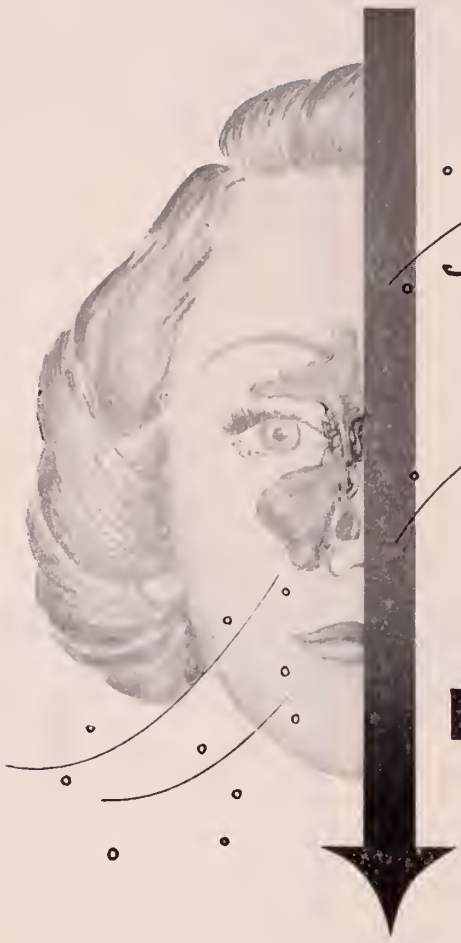
Many urinary tract infections
as well as other infections
rapidly respond to therapy
with this well-tolerated
broad-spectrum antibiotic

Available in a wide variety of convenient dosage forms.

Pfizer

world's largest producer of antibiotics

ANTIBIOTIC DIVISION, CHAS. PFIZER & CO., INC., BROOKLYN 6, N. Y.



To open congested air passages in hay fever

NEO-SYNEPHRINE®

HYDROCHLORIDE

. . . reduces nasal engorgement . . .

. . . promotes aeration . . . encourages drainage

A few drops of Neo-Synephrine 0.25% in each nostril will promptly check mucosal engorgement and hypersecretion, promoting greater breathing comfort over a period of several hours.

The resultant relief to the hay fever sufferer is decidedly gratifying. Prolonged action of Neo-Synephrine makes fewer applications necessary, consequently longer periods of rest and sleep are possible.

Neo-Synephrine does not lose its effectiveness on repeated application and may, therefore, be relied upon to give relief throughout the hay fever season.

Neo-Synephrine is practically free from sting and compensatory congestion; does not appreciably inhibit ciliary activity. Neo-Synephrine has been found relatively free from systemic side effects such as nervous excitation, cardiac reaction or insomnia even when tested on hypertensive, cardiac and hyperthyroid patients.[1]

Supplied in 0.25% solution (plain), bottles of 1 oz., 4 oz. and 16 oz.; 0.25% solution (aromatic), bottles of 1 oz. and 16 oz.; 0.5% solution, bottles of 1 oz.; 1% solution, bottles of 1 oz., 4 oz. and 16 oz.; 0.125 (⅛)% solution, bottles of ½ oz.; 0.5% water soluble jelly, in ⅝ oz. tubes.

1. Van Alyea, O. E., and Donnelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

Neo-Synephrine, trademark reg. U.S. & Canada, brand of phenylephrine.

response in rheumatic fever

q. Does cortisone influence the heart lesions of rheumatic fever?

a. Early cortisone administration suppresses and in some cases may even prevent serious cardiac damage.

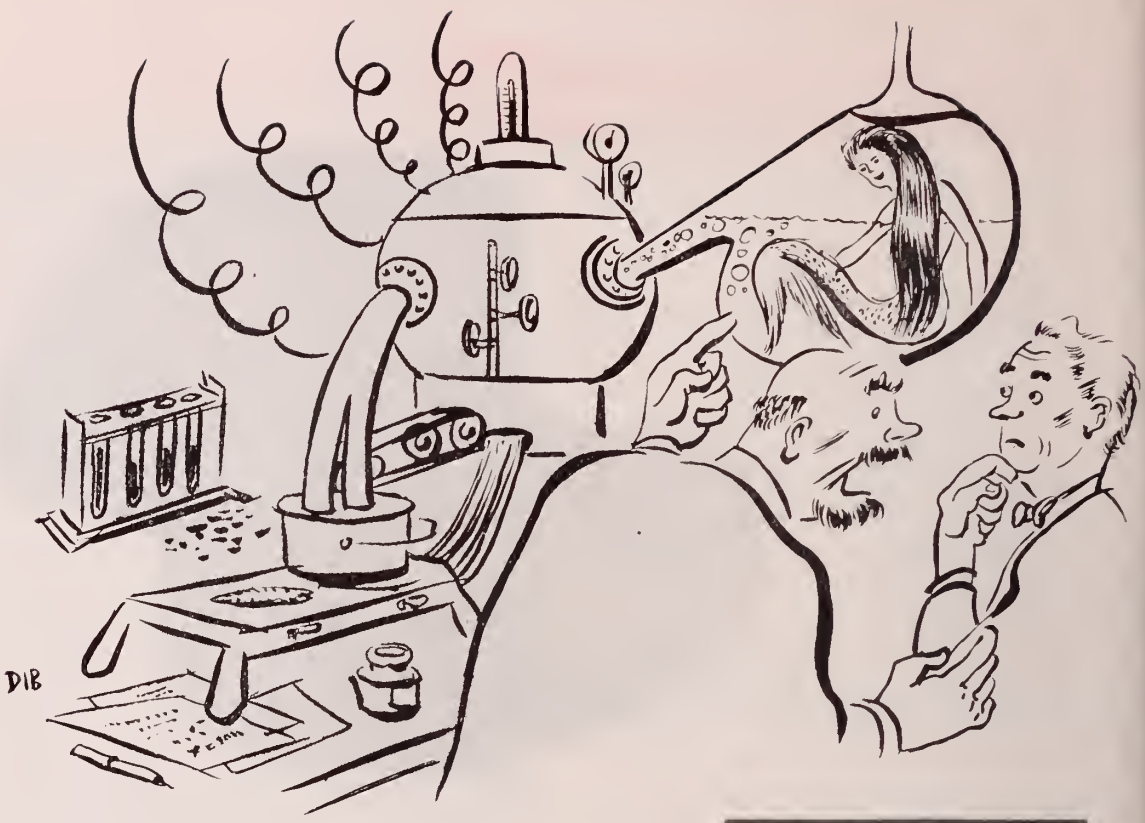
q. What effect does cortisone have on acute rheumatic fever?

a. Often within 24 hours after cortisone therapy, the severely ill, toxic patient appears alert and comfortable; and within one to four days, temperature drops to normal, appetite increases, and polyarthritis subsides.

Cortisone Upjohn

available as Compressed Tablets Cortisone Acetate, 25 mg., for oral use. Bottles of 20 tablets.

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN



"Don't just stand there— **call the MEDICAL SUPPLY MAN!"**

That's always good advice! Although we doubt the Medical Supply Man could do much good here, we'll venture to say this is one of the *few* situations that would stump him! And here's why!

When you call the Medical Supply Man, you get a man trained in his specialty. For repair service you get a man who knows exactly what to do to put faulty equipment back to work in a hurry! If you're having supply problems you get a man who is skilled in inventory control. Or, if you're thinking of new equipment, you get a man who knows the complete story.

So, no matter what your problem — supplies, equipment or repair service — obey that impulse and CALL THE MEDICAL SUPPLY MAN!

HOSPITAL, PHYSICIANS and LABORATORY SUPPLIES & EQUIPMENT

MEDICAL SUPPLY COMPANY

Essentials For Scientific Progress

MIAMI • of JACKSONVILLE • ORLANDO

230 N. E. THIRD ST.
MIAMI 32, FLA.

420 WEST MONROE ST.
JACKSONVILLE 2, FLA.

329 N. ORANGE AVE.
ORLANDO, FLA.

"...particularly beneficial in the treatment of hay fever."[1]

Because CHLOR-*TRIMETON*® maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"[2] it is a drug of choice for hay fever patients.

CHLOR-*TRIMETON*
maleate

1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26, 1950.

Schering CORPORATION
BLOOMFIELD, NEW JERSEY

CHLOR-*TRIMETON*

SCHERING

you couldn't prescribe it—

so we had to make it

Doctors have always wanted a formula for infant feeding that would be as close to human milk as nutritional science could provide.

The problem was immense; the requirements were rigid; the need was great. Borden took up the challenge, and after years of research and many trials and clinical tests the goal was accomplished. BREMIL was made available to the profession.

BREMIL is the first and, to date, the *only* infant food to achieve *all* of these prescription requirements:

. . . conforms to the fatty acid pattern of human milk
. . . conforms to the amino acid pattern of human milk
. . . has a calcium-phosphorus ratio (guaranteed minimum 1½:1) adjusted to the pattern of human milk to prevent tetany
. . . supplies the same carbohydrate as human milk – lactose
. . . is vitamin-adjusted for standards of infant nutrition
. . . offers a human milk size particle curd
. . . is well-tolerated, digested, assimilated

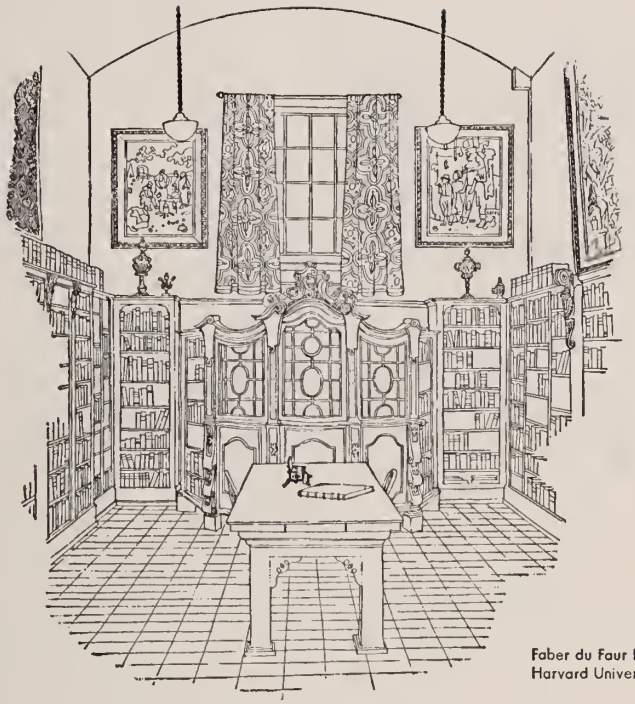
Clinical reference data and samples on request.
Now in drug stores in 1 lb. cans

Bremil® *powdered infant food*

Approximates the milk of the mother

The **BORDEN** Company • 350 Madison Avenue • New York 17

New aureomycin minimal dosage for adults —four 250 mg. capsules daily, with milk.



Faber du Faur Library, Harvard University

From among all antibiotics, Urologists often choose

AUREOMYCIN

Hydrochloride Crystalline

because Aureomycin concentration is much higher in the urine than in the blood, so that very satisfactory therapeutic urinary levels may be reached with moderate oral dosage.

Aureomycin appears in high concentration in the urine, and can be detected for as long as 55 hours after a single oral dose of 0.5 to 0.7 Gm.

Aureomycin serum levels are maintained for as long as 12 hours after oral administration, oral doses of 5 to 10 mg. per kilo at 6-hour intervals being adequate for this purpose.

Aureomycin has its activity greatly increased in an acid medium, rendering it highly useful in the normally acid urine.

Aureomycin has been reported to be useful in infections commonly seen by urologists, including:
Genitourinary infections caused by *E. coli*, *A. aerogenes*, *S. faecalis*, paracolon bacillus, staphylococcus, streptococcus, and enterococcus • Chronic or Resistant Urinary Infection* • Gonorrhea • Nonspecific Urethritis*

Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100. *Ophthalmic:* Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

*When caused by aureomycin-susceptible organisms.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N.Y.

WHEN DIETARY SUPPLEMENTATION IS NEEDED...

what more could a supplement provide?

If the concept of an ideal dietary supplement could be formulated, it might well be one that provides qualitatively every substance of moment in human nutrition. It would provide those for which human daily needs are established as well as others which are considered of value, though their roles and quantitative requirements remain unknown.

How Ovaltine in milk approaches this concept, and how well the recommended three glassfuls daily augment the nutritional intake, is shown in the appended table. The two forms of Ovaltine available—plain and chocolate flavored—are closely alike in their nutrient values.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.7 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*FAT	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

"Doctor Harris, what am I going to do?"

His patients sometimes forget that Dr. Harris also has to rest. Some of them seem to take it for granted that he is as inexhaustible as is his willingness to help. However, because of today's more effective medicines, his patients are getting well faster and night calls are fewer. Recently, therefore, Dr. Harris has been able to take an occasional much-needed rest and still treat more patients successfully than ever before. Furthermore, even long-established pharmaceuticals are gaining in usefulness as a result of such current research as . . .

Lilly

. . . the development of an improved Insulin preparation . . .
NPH Iletin (Insulin, Lilly)

Hagedorn discovered that the antidiabetic effect of Insulin was lengthened by the addition of basic protein precipitants, such as protamines from fish sperm, globins, histones, and kyrins. Since that discovery, there has been a systematic study of many modifications which might simplify still further the management of diabetes.

In co-operation with the Insulin Committee of the University of Toronto, Eli Lilly and Company has actively participated in this search. Over several years, data were accumulated on the action of various modifications of Insulin in more than 5,000 cases. Because of knowledge gained from such studies, many of the difficult, time-consuming problems of diabetic management which once confronted physicians are now overcome by the use of NPH Iletin (Insulin, Lilly).

Lilly ELI LILLY AND COMPANY · INDIANAPOLIS 6, INDIANA, U. S. A.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXIX Jacksonville, Florida, August, 1952 No. 2

The Management of Acute Cholecystitis

WILLIAM J. CLIFFORD, M.D.
AND
HAROLD W. KESCHNER, M.D.
NORTH MIAMI

The purpose of this paper is to present, on the basis of clinical and pathologic observations, a rational plan for the management of acute cholecystitis. By "acute cholecystitis" we refer to that form of the disease accompanied by stone or stones. Noncalculous cholecystitis comprises at the most about 10 per cent of all acute conditions of the gallbladder[1-3] and often represents a single manifestation of inflammation throughout the biliary system. It will not be discussed here.

It is distressing that many general practitioners and internists seem to think that surgery is a last resort in the therapy of acute calculous cholecystitis. Since they are the physicians who see patients with this disease in its early stages, upon them rests the grave responsibility of correct treatment during the acute phase, and in those cases in which surgery is delayed for a valid reason, theirs is the responsibility for the proper advice to the patient once the acute episode has subsided. It is common knowledge that skillful surgery at the time of the first episode of cholecystitis may alleviate all future difficulties. On the other hand, improper treatment, the unjustifiable denial of surgery or the inapt or inadequate surgical procedure, may be followed by morbidity in the form of recurrences and complications which may plague the patient for many years and may indeed be responsible for his death.

Pathogenesis

The intelligent treatment of any disease depends upon an understanding of the pathogenesis and natural history of the disease process. This observation is especially true of acute cholecystitis in which considerable judgment is required to determine the stage of the disease with which one is dealing at any given moment. Despite many years of observation and countless research investigations and despite the fact that acute cholecystitis is a common disease, there still seems to be no unanimity of opinion concerning the etiology and pathogenesis of this disease. As a logical result of this diversity, there is still a considerable variation in the type of treatment instituted and considerable debate concerning the optimum time for surgical intervention in this condition.

Early investigators thought the cause of this disease was primarily bacterial or infectious.[4-7] Repeated cultures of the wall of the gallbladder or the contents of the organ, however, have been sterile in 41 to 58 per cent of cases of acute cholecystitis in which such studies were carried out.[1-5,8]

More recently the role of chemical injury, that is, injury produced by bile, in the pathogenesis of acute cholecystitis has been emphasized by several investigators.[9-11]

It is our belief,[12] along with that of others,[13] that obstruction of the cystic duct, usually by a stone rather than by an inflammatory process, is the first step in the development of acute cholecystitis. Ninety-five to 98 per cent of patients coming to surgery for acute cholecystitis have had gallstones.[13-18] But regardless of what creates the obstruction, profound vascular and lymphatic stasis may occur so abruptly that virtual infarction may result. Increased intravisceral pressure and colicky pains result from the strenuous efforts of the muscular gallbladder to empty itself. This increased pressure interferes with the blood supply of the organ. The venous and lymphatic channels are first obstructed and finally the arterial supply is cut off. Gangrene of the organ may then develop, usually beginning in the fundus since this region is farthest from the source of blood supply. Until extensive edema, great venous congestion with intramural hemorrhage and mucosal desquamation have developed, we do not believe that bile

has any destructive effect on the wall of the gallbladder, for the gallbladder in its physiologic state constantly contains bile. Unless some injury to the lining of the gallbladder occurs, it is difficult to conceive why bile should injure the reservoir for its collection. It is not difficult, however, to understand how a substance such as bile can further injure an organ radically changed by an impaired circulation.

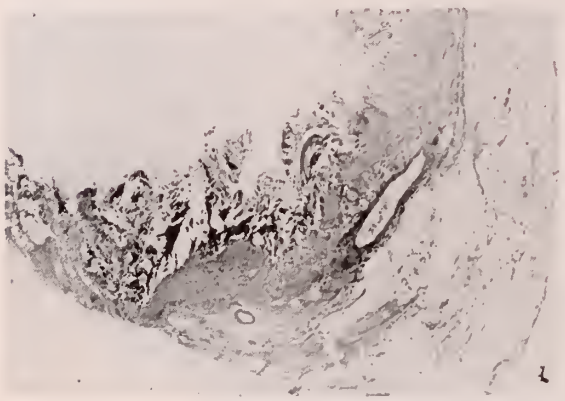


Fig. 1.—Gangrene of the gallbladder. x 12

Hallendorf, Dockerty and Waugh[13] and we have independently noted in sections of gallbladders progressing to gangrene a peculiar lesion of the arteries supplying this organ. Figure 1 shows a typical section through the wall of a gangrenous gallbladder. Figures 2 and 3 illustrate the arterial changes observed in several gangrenous gallbladders. There is pronounced intimal edema and proliferation and considerable subintimal edema. In many instances, we have found that this pathologic process almost completely occluded the lumen of the vessel. This lesion may be an added factor in the production of arterial obstruction early in the course of an acute cholecystitis.

Since gangrene of the gallbladder occurs in most cases in persons over 50 years of age, and since this age group would be more likely to have degenerative vascular diseases such as the one described than a younger age group, we think these findings are more than coincidental. We have speculated on the possibility that this lesion might be part of a widespread vascular change and might well explain by its presence why in some cases the acute condition of the gallbladder progresses to gangrene, and why gangrene occurs predominantly in the older age group. Suffice it to say that when this lesion was found in a gangrenous gallbladder, in most instances it could also be demonstrated widely throughout other organs. Figure 4 shows this lesion in the pancreas of a patient with gangrene of the gallbladder. Furthermore, in a study of patients dying from uremia, this lesion could be found without difficulty in many organs, notably the kidney, the pancreas, and the gallbladder. It has been our observation, too, that arteriosclerosis, as well as hypertension and diabetes, has a higher incidence in those with disease of the biliary tract than in a similar group without it.

In our opinion this lesion plays a definite role in the pathogenesis of acute gangrenous cholecystitis. In many cases in which this lesion exists, the insult of vascular and lymphatic stasis as a result of an impacted stone in the cystic duct has a dramatic effect on the circulation of the gallbladder. Since the circulation is already impaired by the proliferative arterial lesion described, the added injury to the vascular tree may easily produce the necrosis so often observed.

In a certain unknown percentage of cases, perforation of the gallbladder may follow gangrene. Perforation may be of five types, as follows:

1. Perforation communicating with viscus (duodenum, colon or stomach).
2. Perforation and formation of a pericholecystic abscess.
3. Free perforation into the abdominal cavity.
4. Perforation into the liver.
5. Perforation through the abdominal wall.

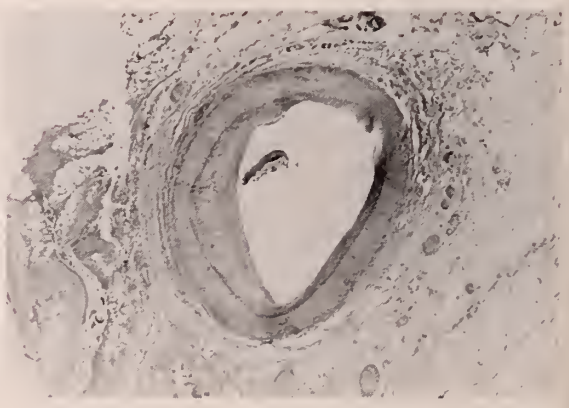


Fig. 2.—Cystic Artery. Case of gangrenous cholecystitis. Advanced atheromatosis with irregularly thickened intima. x 12

This entire sequence of events may be interrupted at any time if the stone becomes dislodged and the contents of the gallbladder are evacuated through normal channels. The progression of this disease, however, to focal or massive gangrene is

not uncommon. One of us has recently reported 100 consecutive cases of acute gangrenous cholecystitis at the Boston City Hospital.[12] It is reasonable then to regard acute cholecystitis as a not uncommon disease which is progressive.

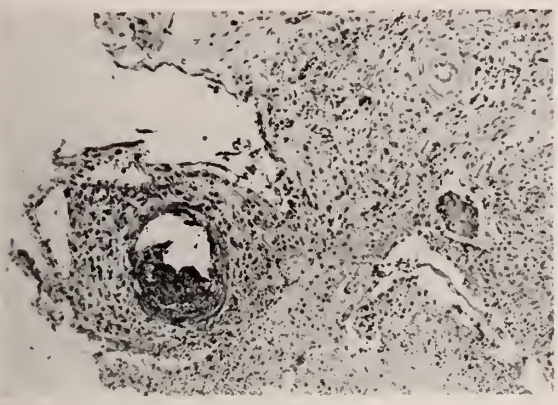


Fig. 3.—Wall of gangrenous gallbladder. Thrombus in vein (lower left) and necrotizing arteritis (upper right). x 81

It is evident from clinical observation[14-16] that focal areas of gangrene or massive gangrene of the gallbladder is far more common than is generally held. Clute and Kenney[19] found localized gangrene in 20 per cent of all hospitalized patients. Thus it would seem that the optimum time for removal of a diseased gallbladder would be during that early period in the course of the disease when the process is confined strictly to the gallbladder itself.

Treatment

The value of early surgical intervention in acute cholecystitis has been demonstrated by the excellent results reported,[17,18] and by statistical studies stressing the forbidding mortality in cases which progress to gangrene.[12] Of all cases of acute cholecystitis, 13 to 25 per cent progress to gangrenous cholecystitis.[20-22] It is easily demonstrable that increasing severity of the disease process is accompanied by a mathematical progression in the mortality rate.

The ideal management of acute cholecystitis then is removal of the gallbladder and, when indicated, thorough exploration of the common bile duct, to be performed as soon as possible within the first 48 to 72 hours after the development of symptoms. This plan means that the patient who enters the hospital with an attack of less than 72 hours' duration should be given the benefit of surgery as soon as the diagnosis is established, as soon as his status as a surgical risk has been carefully determined, and when the fluid and electrolyte balance have been restored to normal limits. Because of the usual delay in seeking medical attention, the not infrequent difficulty in establishing the diagnosis, and the fact that the patient is often acutely ill, it is not always possible to operate within the first 48 to 72 hours. Nevertheless, this ideal is and can be frequently attained, and this method of treatment has produced the lowest mortality.[12,17,18,23]

Furthermore, cholecystectomy is the operation of choice, and whenever possible this procedure should be carried out. It is a one stage procedure and accomplishes the maximum benefit for the patient with minimal mortality and morbidity. When exploration of the common bile duct is indicated, it should be performed at this time.

We believe that exploration of the common duct should be carried out under the following circumstances:

1. When the patient is or has been jaundiced or when there are laboratory evidences of subclinical jaundice.
2. When there is a dilated or thickened common duct, or when there is a palpable stone in the common duct or findings on palpation which are suspicious of stone or stones in this duct.
3. When there are stones in the gallbladder which are small enough to pass through the cystic duct.
4. When dark, sediment-containing bile is obtained by aspiration from the common duct by hypodermic needle and syringe.
5. When acute or subacute pancreatitis is discovered.

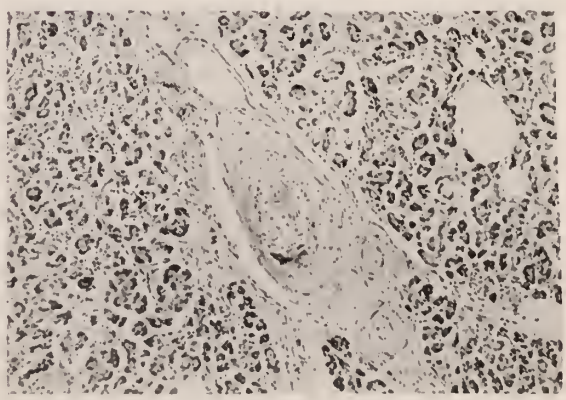


Fig. 4.—Pancreas. From case shown in fig. 3. Hyaline and necrotic change in interlobular vessels. x81

Gradually, the concept that exploration of the common bile duct is a procedure which should be carried out whenever any of these indications exists is becoming generally recognized.[24-26] Now choledochostomy is performed in from 18 to 50 per cent of all cases coming to cholecystectomy in the better clinics.[2,25,27] Stones in the common duct are found in only 50 to 60 per cent of all cases in which choledochostomy is performed. Nevertheless, the consequences of an overlooked stone in the common duct are so serious that opening and exploring the duct are justifiable even on the grounds of suspicion, and certainly must be done if any of the indications mentioned are present.

The only substantial contraindication to choledochostomy would seem to be a patient who is an extremely poor risk and would be unable to stand the slight additional trauma or the slightly increased operating time. A patient of this type is encountered rarely. In such a patient, perhaps the wiser choice would be a preliminary cholecystostomy followed later by a cholecystectomy and choledochostomy. This is especially true in the case of a severely ill and severely jaundiced patient. Jaundice of some degree is present in about 15 per cent of all cases.[28] It may be due to edema of the common duct and the periductal tissue or to a stone in the common duct.

The value of cholecystostomy has been emphasized by many surgeons,[18,20-22,24,25,27,29] but it is still regarded generally as a compromise procedure. It is often the procedure of choice in the seriously ill patient, especially if he is deeply jaundiced, in a patient in whom the disease process is far advanced, with extensive abscess formation for example, and in the patient who has concomitant medical disease of serious import, such as severe diabetes or cardiac decompensation. Cholecystostomy should be performed without hesitancy and without apology when the usual surgical landmarks are obscured or obliterated by the inflammatory process. By utilizing this simpler procedure one lessens considerably the possibility of injuring the common duct, the right hepatic artery, the portal vein or the duodenum.

The decision to abandon a cholecystectomy in favor of the simpler operation is based to a large extent on the skill and experience of the surgeon concerned. The relatively inexperienced surgeon may make such a decision somewhat frequently as compared to the master surgeon of great experience. In any good surgeon's experience, however, there will be a certain irreducible percentage of cases, if the series is large enough, in which wisdom dictates the use of cholecystostomy for any of the reasons given or in order to avoid an inadequate removal of the cystic duct, which in itself is a common cause of postoperative complaints.

Cholecystostomy may be performed as a planned procedure under local anesthesia if necessary. A safe operation, it should always be regarded as the first part of a two stage procedure, with extirpation of the gallbladder to follow in most instances at a later time of election. It is unusual to drain a gallbladder which it is not necessary to remove later. In the aged, debilitated patient, the extremely poor risk, however, it may be better judgment to postpone the second stage extirpation of the gallbladder for an indefinite period provided a cholecystocholangiogram demonstrating patency of the cystic duct and absence of stones in the common duct is obtained and provided there is a continuing asymptomatic course.

In our experience, a cholecystectomy should not be too long postponed after the initial drainage of the gallbladder. This second stage operation can ordinarily be planned about three months after the cholecystostomy. In this fashion, considerable pain and discomfort can usually be spared the patient, and he can be adequately prepared for the logical second stage of a two stage procedure.

The poor general condition of the patient, the difficulty in diagnosis, or the patient's reluctance to seek medical attention may force one to delay surgery. Delay should rarely be necessary, but if it is, the progress of the disease must be most carefully followed. Fluid balance should be promptly restored, and penicillin and vitamin K are given in the usual doses. The temperature, pulse rate and pertinent laboratory data are checked at frequent intervals, and the symptoms and signs are carefully and frequently evaluated. A continued rise in temperature, pulse rate and white blood cell count, and, even more important, a failure in improvement or a change for the worse in the general condition of the patient are indications for abandoning these conservative measures and performing prompt surgery. Nevertheless, in a small percentage of cases for adequate reasons, generally because of concomitant medical diseases, it may be justifiable to postpone surgery. Surgery is not infrequently postponed to improve the general condition of the patient; it is seldom if ever permanently withheld.

It must be remembered that when an operation is deferred for any great length of time, serious

attacks may occur unexpectedly during the waiting interval. This fact should be carefully considered in evaluating the policy to be followed in an individual instance.

It is clear that in a majority of cases in which nonsurgical therapy is employed, the symptoms will subside. One, however, must not be lulled into the misconception that the disease is cured because the symptoms subside. Repeated severe future attacks, with a greater incidence of gangrene and perforation, are almost certain to follow. Furthermore, adenocarcinoma of the gallbladder is not an infrequent complication of calculous cholecystitis.[30] Graham[31] reported that 8.5 per cent of all proved cases of cholelithiasis were associated with carcinoma of the gallbladder or bile ducts. Perhaps Mohardt's figure of 5.0 per cent, arrived at after a painstaking review of the literature, is a fairly accurate one.[32] The incidence of gallstones in cases of malignant disease of the gallbladder is high, ranging in different series from 55 to 87 per cent.[33] Any one of these figures may be construed as another forceful argument for prompt surgical treatment. The mortality and morbidity are directly related to hesitancy in instituting early surgery. Prompt surgical intervention is indicated in the usual case.

There may be extremely rare instances when the patient may be denied the benefit of surgical therapy for good and sufficient reasons. Dunphy and Ross[26] reported 3 such examples in 134 cases.

The short period prior to surgical intervention should be utilized to prepare the patient carefully. The fluid and electrolyte balance should be restored to normal limits. To accomplish this end may entail repeated laboratory examination, but in the elderly or seriously ill patient the time is well spent. If the patient is severely jaundiced, prothrombin determinations may be made and a thorough evaluation of bleeding tendencies completed. If secondary anemia is present, or poor prothrombin values or evidences of bleeding tendencies, they should be corrected by all available methods including transfusions.

The use of the Miller-Abbott tube is an important part of the preoperative preparation of the patient. In this regard, gallstone ileus, the result of perforation of a gallstone into the intestine, has received considerable attention in the literature. In the series of cases of perforated gallbladder reported by Blain and Harkins,[34] in 27 per cent of the cases there were associated signs of intestinal obstruction, but less than half of these were examples of classic gallstone ileus. The remaining cases were produced by perforation with resulting inflammatory or paralytic ileus or mechanical obstruction as by adhesions. In the series of 100 cases of acute gangrenous cholecystitis recently reported by one of us,[12] there were 4 cases of proved gallstone ileus and 23 cases of paralytic ileus produced by perforation of the gallbladder. Distention on either basis, clinically and easily demonstrated on flat abdominal films, is not an uncommon finding in those cases which progress to gangrene. In all cases of acute cholecystitis, it has been our policy to begin Wangensteen suction shortly after the patient enters the hospital and to maintain it for at least 48 hours after surgery. This suction reduces the morbidity considerably in our opinion.

It has been shown experimentally in dogs[35] that sulfonamides given parenterally will not be recovered from the gallbladder of animals whose cystic ducts are completely occluded. Zaslow, Counseller and Heilman [36] demonstrated the same lack of recovery in human beings of penicillin and streptomycin. This is an interesting observation, since in many cases of acute cholecystitis and in most cases of acute gangrenous cholecystitis, obstruction of the cystic duct occurs. The effectiveness of these drugs, therefore, is definitely limited in cases in which obstruction is present. Despite the belief that sulfa drugs, penicillin and streptomycin are of little value in the biliary tree when obstruction exists, they are routinely given in such cases on admission of the patient to the hospital and are continued postoperatively, but only as an adjunct to surgery. Since we believe that obstruction is a prominent factor in the development of an exceedingly high percentage of cases of acute cholecystitis, no undue reliance is placed on the effectiveness of these drugs, except as they limit the spread of infection outside the biliary tree.

It would seem logical then to assess each patient individually, to treat each patient with acute cholecystitis as a distinct problem, bearing in mind the general rules laid down here. By evaluating each patient on the merits of his particular case, by coming to a decision in view of the established generalities previously made, by constantly bearing in mind the kinetic nature of the local pathologic process, and by preserving a flexibility of mode of treatment, not only a willingness to change the therapy according to the indications in one case as compared to another but also a willingness to mod-

ify quickly and on a rational basis the treatment in a particular case as dictated by changing symptoms or signs, the percentage of error can be materially reduced. Acute cholecystitis is a disease par excellence to be treated by individualizing each case, a disease in which patience and surgical judgment culminated by technical skill pay dividends of lowered mortality and morbidity.

To recapitulate briefly, we believe that cholecystectomy with choledochostomy, as indicated, should be performed within the first 72 hours after the onset of symptoms of acute cholecystitis. In each case there should be a definite but flexible plan of treatment for the management of this kinetic disease. If for adequate reasons, it is impossible to carry out a policy of early surgery, the patient's condition should be followed with extreme care and surgery performed on the indications discussed. In our opinion surgery in certain, but few, instances may be deferred. Almost never is it permanently withheld.

Summary

A mode of development of acute cholecystitis is presented, in which obstruction and vascular changes play prominent roles.

Early surgery, cholecystectomy or cholecystostomy, is emphasized as the best method of treatment.

The indications for exploration of the common bile duct are reviewed.

The wisdom of evaluating the patient as a whole is stressed.

A flexible plan of treatment is outlined.

References

1. Goldman, L.; Morgan, J. A., and Kay, J.: Acute Cholecystitis; Correlation of Bacteriology and Mortality, Gastroenterology 11:318-325 (Sept.) 1948.
2. Adams, R., and Stranahan, A.: Cholecystitis and Cholelithiasis; Analytical Report of 1,104 Operative Cases, Surg., Gynec. & Obst. 85:776-784 (Dec.) 1947.
3. Fallis, L. S., and McClure, R. D.: Acute Cholecystitis; Review of 320 Cases, Surg., Gynec. & Obst. 70:1022-1028 (Jan.) 1940.
4. Rehfuss, M. E., and Nelson, G. M.: Problem of Infection in Gall Bladder Disease with Report on Experimental Production of Cholecystitis, Am. J. Digest Dis. and Nutrition 1:759-768 (Jan.) 1935.
5. Rosenow, E. C.: Focal Infection and Elective Localization of Bacteria in Appendicitis, Ulcer of Stomach, Cholecystitis and Pancreatitis, Surg., Gynec. & Obst. 33:19-26 (July) 1921.
6. Vest, S. A., Jr.: Gangrene of Gallbladder; Report of Cases, Internat. S. Digest 15:131-160 (March) 1933.
7. Cottam, G. G.: Gangrenous Cholecystitis, Surg., Gynec. & Obst. 25:192-194 (Aug.) 1917.
8. Andrews, E., and Henry, L. D.: Bacteriology of Normal and Diseased Gallbladders, Arch. Int. Med. 56:1171-1188 (Dec.) 1935.
9. Colp, R.; Gerber, I. E., and Doubilet, H.: Acute Cholecystitis Associated with Pancreatic Reflux, Ann. Surg. 103:67-76 (Jan.) 1936.
10. Womack, N. A., and Bricker, E. M.: Pathological Changes in Gallbladder Wall Due to Action of Bile, Proc. Soc. Exper. Biol. & Med. 45:710-712 (Nov.) 1940.
11. Womack, N. A., and Bricker, E. M.: Pathogenesis of Cholecystitis, Arch. Surg. 44:658-676 (April) 1942.
12. Clifford, W. J.: Acute Gangrenous Cholecystitis, New England J. Med. 241: 640-643 (Oct. 27) 1949.
13. Hallendorf, L. C.; Dockerty, M. B., and Waugh, J. M.: Gangrenous Cholecystitis; Clinical and Pathologic Study of 100 Cases, S. Clin. North America 28:979-998 (Aug.) 1948.
14. Eliason, E. L., and Stevens, L. W.: Acute Cholecystitis, Surg., Gynec. & Obst. 78:98-103 (Jan.) 1944.
15. Blumberg, N., and Zisserman, L.: Acute Suppurative and Gangrenous Cholecystitis, Am. J. Surg. 70:38-48 (Oct.) 1945.
16. Cowley, L. L., and Harkins, H. N.: Perforation of Gall Bladder; Study of 25 Consecutive Cases, Surg., Gynec. & Obst. 77:661-668 (Dec.) 1943.
17. Heuer, G. J.: Factors Leading to Death in Operations Upon Gall-Bladder and Bile-Ducts, Ann. Surg. 99:881-892 (June) 1934.
18. Glenn, F.: Surgical Treatment of Acute Cholecystitis, Surgery 23:397-404 (March) 1948.
19. Clute, H. M., and Kenney, F. R.: Surgical Aspects of Gallstones, New England J. Med. 231:783-785 (Dec. 14) 1944.
20. Judd, E. S., and Waldron, G. W.: Gangrenous Gallbladder, Minnesota Med. 17:576-578 (Oct.) 1934.
21. Zinninger, M. M.: Surgical Treatment of Acute Cholecystitis Ann. Surg. 96:406-412 (Sept.) 1932.
22. Diffenbaugh, W. G.; Sarver, F. E., and Strohl, E. L.: Gangrenous Perforation of Gallbladder; Analysis of 19 Cases, Arch. Surg. 59:742-749 (Sept.) 1949.
23. Stone, H. B., and Owings, J. C.: Acute Gall-Bladder as Surgical Emergency, Ann. Surg. 98:760-765 (Oct.) 1933.
24. Cattell, R. B.: Biliary Tract Surgery; Statistical Review, S. Clin. North America 23:644-646 (June) 1943.
25. Colcock, B. P.: Choledochostomy; Its Place in Surgery of Biliary Tract, S. Clin. North America 28:641-647 (June) 1948.
26. Dunphy, J. E., and Ross, F. P.: Studies in Acute Cholecystitis; Surgical Management and Results, Surgery 26:539-547 (Sept.) 1949.
27. Lahey, F. H.: Third Era in Surgical Treatment of Cholelithiasis — Removal of All Stones in the Ducts, Surg., Gynec. & Obst. 67:698-699 (Nov.) 1938.
28. Eckel, J. H.: Acute Cholecystitis, S. Clin. North America 30:451-459 (April) 1950.
29. Zollinger, R., and Cutler, E. C.: Treatment of Acute Cholecystitis; Evaluation, J. A. M. A. 121:481-485 (Feb. 13) 1943.
30. Johnston, J. H., Jr.; Acute Cholecystitis, South. Surgeon 14:683-689 (Oct.) 1948.
31. Graham, cited by Cole, W. H.: Tumors of Gallbladder and Bile Duct, in Christopher, F.: A Textbook of Surgery by American Authors, ed. 4, Philadelphia, W. B. Saunders Company, 1945, p. 1143.
32. Mohardt, J. H.: Carcinoma of Gall Bladder; Collective Review, Internat. Abstr. Surg. 69:440-451, 1939; in Surg., Gynec. & Obst. (Nov.) 1939.
33. Judd, E. S., and Gray, H. K.: Carcinoma of Gall Bladder and Bile Ducts, Surg., Gynec. & Obst. 55:308-315 (Sept.) 1932.
34. Blain, A., III, and Harkins, H. N.: Intestinal Obstruction Due to Perforations of Gall Bladder; Analysis of 41 Cases of Perforated Gall Bladder in 11 of Which There Was Associated Intestinal Obstruction, Surgery 21:110-135 (Jan.) 1947.
35. Lynn, D., Bergh, G. S., and Spink, W. W.: Failure to Recover Sulfonamides from Gall Bladder in Dogs with Cystic Duct Obstruction, Surgery 13:447-449 (March) 1943.
36. Zaslow, J.; Counseller, V. S., and Heilman, F. R.: Excretion and Concentration of Penicillin and Streptomycin in Abnormal Human Biliary Tract; Gall Bladder, Surg. Gynec. & Obst. 84:16-20 (Jan.) 1947.

685 North East 126th Street.

Accidents Among Florida Children Leading Cause of Death

Hugh A. Carithers, M.D.
Jacksonville

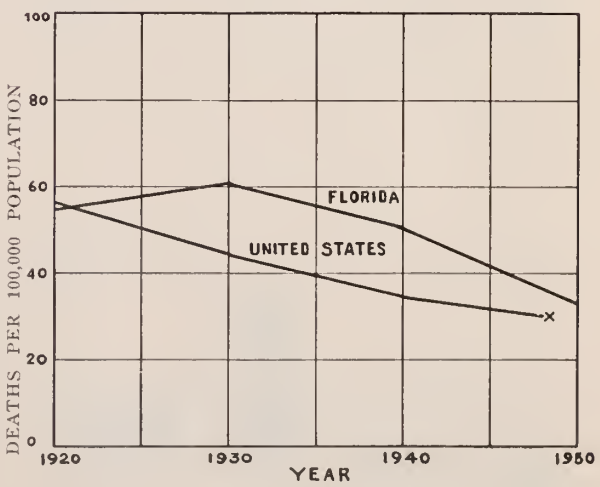
Accidents are the leading cause of death among children in the United States. Approximately 11,000 children between the ages of 1 and 14 years are killed each year by accidental means, and it is estimated that for every fatality there are probably 100 injured, of whom 4 receive permanent disability.[1] Among children accidents cause far more fatalities than pneumonia, diarrhea and enteritis, measles, diphtheria, whooping cough, scarlet fever, meningitis and poliomyelitis combined. The prominence of accident mortality in childhood in recent years is due in part to the lowering of mortality from communicable disease by immunization, the control of acute infections by drugs, and the application of the science of nutrition.

In Florida there is a higher death rate from accidents to children than in the nation as a whole (fig. 1). In 1950, there were 293 fatal accidents to children under 15 years of age in the state. This number would indicate an incidence of approximately 30,000 injuries, of which over 1,200 were permanently disabling. In considering the problem of accidents to Florida children, comparison between mortality figures in 1930 and 1950 will be made. The causes of fatal accidents to the children of the state in 1950 will be considered in some detail.

There are advantages in considering mortality figures among children according to age group. In 1930 in Florida in children aged 1 through 4, accidents were the third cause of death (fig. 2), being exceeded by pneumonia and influenza, and diarrhea and enteritis. In 1950 accidents were the first cause, exceeding in number the four next most common causes combined. In an older age group, aged 5 through 14, accidents were the leading cause of death in 1930 as well as 1950 (fig. 3), but between those years such prominent causes of mortality as malaria, rheumatic heart disease and appendicitis have almost disappeared. The number of deaths from accidents, however, has continued to remain alarmingly high.

Figure 4, delineating the relative decrease in accidents and certain diseases in recent years, shows an astounding reduction of mortality among Florida children during the two decades between 1930 and 1950. Malaria has been completely eliminated as a killer, diarrhea and enteritis have been reduced 95 per cent, childhood communicable disease 95 per cent, appendicitis 91 per cent, tuberculosis 83 per cent, rheumatic fever and heart disease each 83 per cent and pneumonia 77 per cent. Deaths from accidents, however, have shown a reduction of only 45 per cent.

Comparison of Fatal Accident Rates Among Children Ages 1-14, Florida and the United States 1920-1950



x 1948 data latest available for United States

Figure 1

Read before the Florida Health Officers' Society, Seventh Annual Meeting, Hollywood, April 27, 1952.

Consideration of these figures indicates that Florida physicians, and, indeed, all citizens, have a challenge to accept the fact that accidents are the greatest threat to the lives and health of our children and that accident prevention must become a responsibility of all who deal with children. Experience in industry, in a few controlled traffic studies and in some schools has proved that accidents are not merely unavoidable acts of God, but that morbidity and mortality from them can be greatly reduced by intelligent, and often simple, measures.

Leading Causes of Death Among Children Ages 1-4 With Death Rates Per 100,000 Population, Florida 1950 and 1930

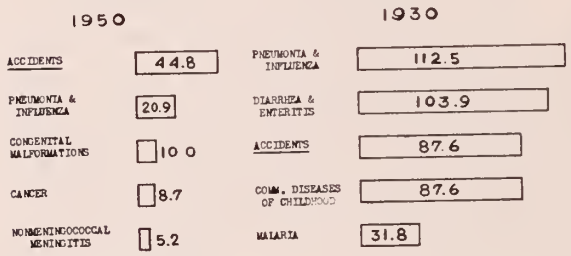


Figure 2

Types of Accidents

As shown in figure 5, over one fourth of all accidents in 1950 among Florida children aged 1 through 14 occurred in or around the home. In the younger age group, aged 1 through 4, almost half of the fatal accidents occurred in the home environment. This incidence emphasizes the fact that among young children, education of the parents in accident prevention is the important factor in lowering mortality and morbidity, while among older children, who spend considerable time away from direct parental supervision, education of the child himself becomes of more importance in lowering mortality.

Table 1 indicates the types of accidents occurring to Florida children in the years 1930 and 1950, with the percentage change between these years.

TRANSPORTATION.—Motor vehicle and other transportation accidents are the leading cause of mortality from accidents among Florida children. They account for about 29 per cent of the total. It is important to realize, however, that in almost half of these accidents the children were pedestrians. In the younger age group, below the age of 5 years, 85 per cent of traffic deaths in 1950 were among pedestrians. Vehicles running into children at play in the street and often in driveways are preventable accidents of major importance.

Leading Causes of Death Among Children Ages 5-14 With Death Rates Per 100,000 Population, Florida 1950 and 1930

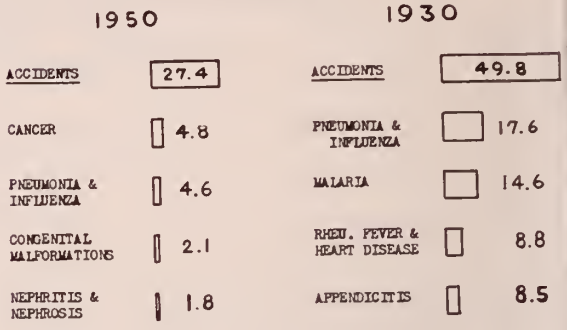


Figure 3

DROWNING.—The second most common cause of accidental death among Florida children aged 1 through 14 years is drowning. In a state containing many lakes and a long shore line, the prominence of this cause may not be surprising. Deaths from drowning have shown the only increase among 8 accidental causes in Florida children between the years 1930 and 1950. For the nation as a whole, the reported mortality from drowning among children aged 1 through 14 is 5 per 100,000 population. Florida's death rate, in 1950, was 8.1 per 100,000 population. Among the younger age group, the incidence of drowning from falls in lily pools and fish ponds in their own or in

Table 1.—Accidental Deaths and Death Rates for Children Aged 1-14 Years According to Type of Accident, Florida, 1930 and 1950

Type of Accident	Deaths 1950	Deaths 1930	Death Rate per 100,000 Population 1950	Death Rate per 100,000 Population 1930	Percentage Change 1930-1950
All accidents	222	249	33.4	60.5	—45%
Motor vehicle and other transportation	92	76	13.9	18.5	—25%
Drowning	54	32	8.1	7.8	+ 4%
Burns and conflagration	29	48	4.4	11.7	—62%
Poisoning	13	19	2.0	4.6	—57%
Firearms	8	25	1.2	6.1	—80%
Other accidents	26	49	4.0	11.9	—66%

neighbors' yards is extremely high. Among the older age group, drowning at the seashore, in lakes and in swimming pools is a more common cause of death.

Accidents Versus Certain Diseases Percent Decrease in Death Rates For Certain Diseases Among Children Ages 1-14 Between 1930 and 1950, Florida

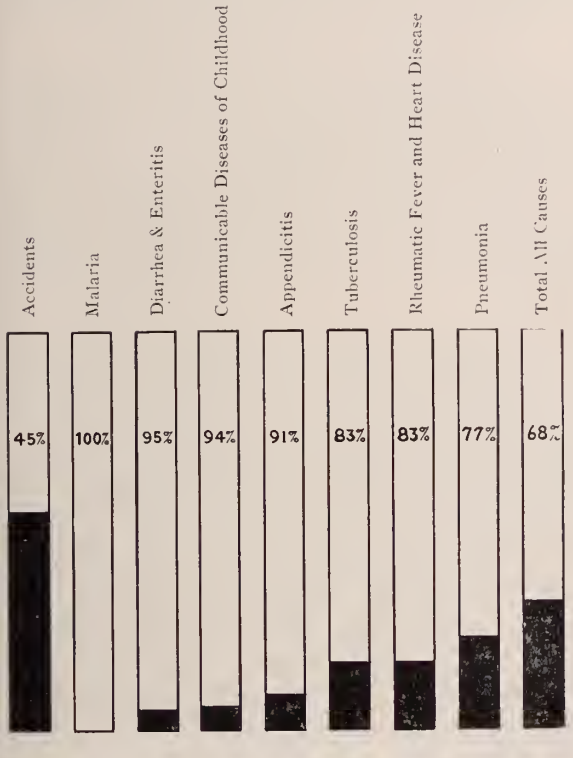


Figure 4

Burns.—Deaths from burns and conflagration among Florida children have shown a considerable reduction since 1930, about 62 per cent. The figures for morbidity from burns are not available. The reduction in mortality is no doubt due, in part, to the improved treatment of burns effected by modern medical methods. In many cases of severe burn, patients who formerly died are now being saved. Prevention of the original accident, all would agree, is more desirable than better means of treatment.

Poisoning.—Deaths from poisoning remain tragically high and most of them occur in the younger age group, aged 1 through 4. Ingestion of household cleaning agents, medicines from the family medicine cabinets, insecticides and inflammable liquids accounts for a great majority of deaths from poisoning. It is a common observation that during the "age of inquisitiveness," between 1 and 3 years, some children will eat or drink anything. Accounting for a relatively low mortality but a high morbidity from poisoning among Florida children is ingestion of kerosene. Among the 26 children with kerosene poisoning treated by me in the last six years, all except 1 showed roentgen or other evidence of pneumonia 24 or more hours after ingestion of the substance. None of the children died, however.

Firearms.—Accidental deaths from firearms showed an 80 per cent decrease in 1950 over the year 1930 among Florida children aged 1 through 14. There were 8 deaths in 1950 caused by firearms among the children of the state.

Other Accidents.—The inhalation or ingestion of objects causing suffocation and obstruction, accidental mechanical suffocation, accidents caused by animals, aircraft accidents, and the like, account for 26 of the 222 fatal accidents occurring to Florida children aged 1 through 14 in 1950. Accidental mechanical suffocation, while not an important cause of death among children over 1 year of age, was the leading cause of death from accidents among infants in Florida during 1950.

Accident Proneness

Over 30 years ago Greenwood and Woods,[2] investigating industrial accidents, concluded that about 20 per cent of the population have over 50 per cent of the accidents. The presence of an accident-prone group in the general population has been well established by subsequent studies. Among children, too, accident proneness is readily observed, although research into this phase of the accident problem needs to be done. Gleason[3] ad-

Death Rates Per 100,000 Children by Age Groups According to Home or Other Place of Accident, Florida, 1950

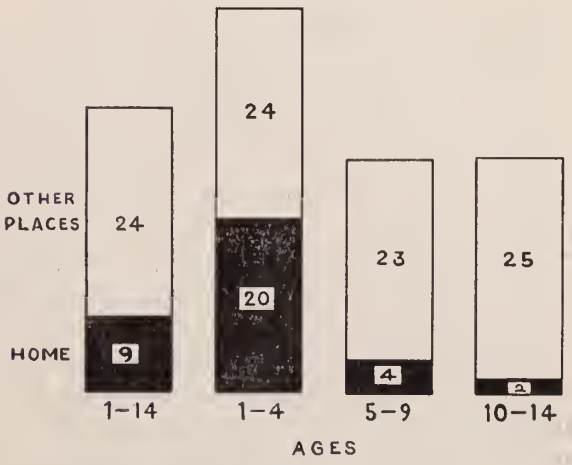


Figure 5

vocated the formation of clinics for accident-prone persons, realizing that after all safety factors are introduced into one's environment, repeated accidents indicate the need for detailed investigation of the individual himself. Paraphrasing a colleague's remark, this author commented, "It is more important what kind of a fellah has an accident than what kind of an accident the fellah has."

Investigation of the accident-prone should include a thorough physical appraisal, with special emphasis on vision, hearing, orthopedic status and neurologic integrity. Not infrequently, as an example, one will discover that a child who has repeated falls, sometimes serious ones, has an orthopedic defect of the lower extremities. Slight petit mal and psychomotor attacks of epilepsy may be an occult factor in accident repeaters, especially in childhood, and whenever a suspicion exists in the mind of the examiner that such is the case, an electroencephalogram is indicated.

The investigation of the psychic factors involved in the accident-prone patient may sometimes be rewarding. The theory that some accident repeaters have a guilt complex, conscious or subconscious, and that their accidents are manifestations of self punishment is accepted by some authorities. The proneness to accidents of the completely rejected child who apparently cares little about anything, including his own well-being, has been observed. Other children in a rash bid for attention may repeatedly incur accidents. If the chronic accident repeater is in a relatively safe environment and has no physical defects, psychic factors should be sought which might account for his affliction.

The Physician's Role in Accident Prevention

Education of parents especially, and of children to a less extent, is the keystone of accident prevention. Physicians, particularly general practitioners, who care for about three fifths of the children of Florida,[4] have more opportunity to educate the parents of growing children in accident prevention than any other group. Not only does the family doctor see the child after an accident has taken place, but he knows in many cases when a particular child is already receiving overprotection or underprotection. He can utilize his knowledge of home and family situations to channel protection toward a common sense level.

In the case of older children, who are away from home most of the day, the physician can be a potent influence in accident prevention. He has the opportunity to point out to parents that their supervision of the child does not end abruptly with his entrance into kindergarten or school and that they themselves must educate the child in safety measures to be taken away from home.

More specifically, all physicians who treat children may make a part of their routine practice most of the following suggestions:

1. Education of parents in accident prevention should begin before the child learns to walk. Mention the common home accidents at well child check-ups, whether in private office or clinic. Distribute pamphlets on accident prevention; they are available for the asking from several leading insurance companies and the National Safety Council.

2. On calls into the homes of children, observe unsafe conditions and suggest corrective measures.

3. When treating any accident, inquire into the cause and tactfully point out how a recurrence can be prevented in the future. There is no better time than while treating an accidentally injured child to make the parents and the child himself aware that safety measures are of value.

4. In prescribing drugs, stress the dangers of injudicious use and careless storage. This is also a good time to inquire about the handling of harmful cleaning agents, insecticides and fuel in the home.

5. When a child has repeated accidents, make a complete appraisal of the patient and his environment in an attempt to find the cause. Public health nurses may be of value in such a study.

6. As a guardian of public health and well-being, be a leader in community projects and an educator in safety measures.

Summary

Accidents are the first cause of death among children and a foremost cause of child morbidity in the nation today. Florida has a higher death rate among its children from this cause than the country as a whole. The figures presented and the comparisons made represent a challenge to all citizens of the state and especially to Florida physicians to assume full responsibility for a constructive and continuous accident prevention program. Certainly, progress in reducing mortality from accidents among Florida children in recent

years has failed by a wide margin to keep pace with the impressive reduction in mortality from disease.

The types of accidents for the years 1930 and 1950 are analyzed, and accident proneness is discussed. In addition, specific suggestions are made to physicians regarding their important role in accident prevention among children.

Appreciation is expressed to Mr. Everett H. Williams, Jr., Director of the Bureau of Vital Statistics of the Florida State Board of Health, for statistical data.

References

1. Wheatley, G. M.: Accident Prevention and the General Practitioner, Postgrad. Med. 10:442-445 (Nov.) 1951.
2. Culpin, M.: Prevention of Accidents, Lancet 1:1077-1080 (May 19) 1934.
3. Gleason, M. N.: The Accident-Prone Patient, New York State J. Med. 48:2168-2170 (Oct. 1) 1948.
4. Child Health Services in Florida, Report of The Florida State Pediatric Association Study of Child Health Services Made with the Cooperation of the Florida State Board of Health. Published by The Florida State Board of Health, 1947.

2000 Park Street.

Thrombotic Thrombocytopenic Purpura

Nathan L. Marcus, M.D.
TAMPA

Only 25 cases of thrombotic thrombocytopenic purpura were recorded in the American literature prior to September 1950. Certainly cognizant necropsy and hematologic studies would have revealed more, when, in a city of approximately 150,000, within a period of one month there were 2 reported deaths, 1 in a man aged 45, and 1 in a woman aged 31 whose case is reported here. In both cases the diagnosis was confirmed by autopsy and corroborated by authorities on this subject.

The paucity may be explained by the inability to diagnose the disease correctly due to the unawareness of the physician that such a syndrome or disease actually exists, or the lack of sufficient autopsy material. From the medical textbook and encyclopedia standpoint, as well as that of the many volumes of scientific periodicals, one would have great difficulty in finding reference to this subject until the past year or two.

I hope this article will stimulate enough enthusiasm so that, with possible antemortem diagnoses and investigative in vivo studies, a clinical cure may be anticipated in the future.

Nomenclature

There are various names for this syndrome, such as diffuse or generalized platelet thromboses with thrombocytopenia and hemolytic anemia, disseminated arteriolar and capillary platelet thrombosis, and thrombotic thrombocytopenic purpura. The last seems to be the one in vogue at this writing. Other names are to be noted in the references.

Definition

Thrombotic thrombocytopenic purpura is a disease, probably a symptom complex of still unknown etiology characterized in general by: (1) acute, febrile illness of one to three weeks, frequently fulminating; (2) thrombocytopenia, with its petechiae, ecchymoses, prolonged bleeding time, poor clot retraction; and hemolytic anemia, with its jaundice and free hemoglobinemia; and little alteration in the coagulation and prothrombin time; (3) severe anemia out of proportion to any observed blood loss; (4) tendency to leukemoid reaction in the peripheral blood; (5) transitory neurologic and mental signs and symptoms; and (6) the fact that to date proved cases have been invariably fatal.

History

The first record of this disease dates back to 1925 when Moschcowitz[1] described a case including autopsy findings which fits the pattern of this syndrome. The patient was a girl aged 16, who died within two weeks of her illness. Unfortunately, platelet counts and other detailed laboratory work were not available. Since 1925, sporadic cases have been reported in the literature, in 2 of which[2,3] the diagnosis was made or suspected antemortem. In Modern Medicine, April 1, 1951, under Diagnostix, a similar case is reported with antemortem diagnosis, confirmed by autopsy.

Etiology

The etiology is not known; however, most of the literature and experimental studies seem to

point toward an antigen antibody reaction or a toxin. Experimentally, by inducing the Shwartzman phenomenon in animals one may produce superficially a syndrome, venule involvement primarily,[4] similar to that occurring in this condition. Gore[5] seemed to attribute this disease to an endothelial lesion with secondary accumulation of platelets at this site. The possible significance of a hypersensitivity reaction to drugs or bacterial agents must also be considered.

Heredity apparently has no definite relationship, although a brother of one patient[6] died of periarteritis nodosa, and the sister of another[7] died of typical generalized lupus erythematosus, these being cases of diffuse vascular disease.

Whatever the causative mechanism or agent, the platelets and endothelial lining of the small arterioles and capillaries are injured; and not only the patient's blood cells but also transfused cells and blood as well are destroyed.

Eighty per cent of the cases reported have been in young white women. Rarely, however, cases have been observed in the opposite sex, and in the Negro. The average age is 23.8 years, the range being from 9½ to 50 years.[8]

Pathologic Physiology

Histologically, there are multiple hyaline thrombi consisting of accumulations of platelets plugging the small arterioles and capillaries of almost all organs of the body. There is a reactive endothelial proliferation within the blood vessels. The characteristic feature is absence of inflammatory reaction in the walls of the vessels and adjacent tissue,[9] the lesion consisting of a segmental accumulation of hyaline material beneath the endothelium of a capillary, and between the endothelium and musculature of an arteriole.[5]

The venules are practically never involved, nor are the larger blood vessels. The thrombi are most numerous in the heart, brain, kidneys, adrenals, pancreas and intestinal tract, but no organ or system is immune. Many of the blood vessels are occluded; but some escape, and it is this apparent collateral circulation that probably accounts for the many transitory phenomena, particularly of the neurologic system.

Hemolytic anemia is present, the degree varying in cases reported. There is no direct evidence of disturbed splenic function.

The cause of death is the widespread purpura with hemorrhage into the vital organs of the body. The illness as a rule is not prolonged sufficiently for a septicemic process to intervene.

Hematologic Investigation

The minute details of the study of this disease require the services of a clinical laboratory and a pathologist well versed in this subject. Guidance in this direction should remain in the hematologist's domain.

Suffice it to summarize: There is anemia of great degree, normocytic and normochromic (as a rule the red blood cell count cannot be raised to any degree by blood transfusions), increased reticulocytes, increased icteric index and serum bilirubin, diminished platelet count almost to zero before death (the platelets are removed from the circulation by agglomeration or agglutination in the thrombi, rather than there being generalized deficiency per se); the total white blood cell count with a neutrophil shift to the left is usually moderately increased, and often shows a leukemoid reaction which may confuse the peripheral blood picture with that of leukemia; there is no eosinophilia.

Singer, Motulsky and Shanberge,[2] particularly conscious of this syndrome, offered additional analysis derived from a case, the diagnosis being suspected antemortem. Fragility studies revealed increase in osmotic and mechanical fragility, but normal resistance to lysolecithin and heat. The Coombs antiglobulin test gave negative results; when sufficient cases are reported to evaluate the significance of this negative reaction, perhaps the hemolytic phase of this disease might be better classified. The bone marrow interpretation is as follows: a pronounced erythroid hyperplasia; the manufacture of thrombocytes apparently not inhibited; large amounts of hemosiderin noted, a common observation in hemolytic anemia or red cell destruction; inability to demonstrate platelet thromboses in the bone marrow in this case (a fact not in accord with one of another recent study[5]).

With these facts in mind the hematologist might ideally substantiate his diagnosis by biopsy of tissue with its vascular pattern, or bone marrow with its morphologic changes.[5]

Symptoms

The onset, although usually abrupt with malaise, weakness, fever frequently with a chill, and often symptoms suspicious of a respiratory infection, may however intervene during the course of a chronic illness or a period of vague poor health. The variable onset, easily understood by reviewing the pathologic physiology, may vary from vague abdominal pains to severe neurologic pains. The patient's fever with frequent chills is probably due

to the hemolysis as well as the free hemorrhage into the body tissues.

The illness may be ushered in with signs and symptoms suggestive of an acute blood dyscrasia, or the blood disturbances may occur shortly after the onset of the illness.

In addition to the blood disturbances, the most characteristic feature of this illness is the neurologic as well as the mental disturbance, severe and yet as a rule nonlocalizing and transitory. Symptoms suggesting disseminated injury to the brain or spinal cord may be anticipated; facial weaknesses, dizziness, headaches, spasticity, partial paralysis, mental aberrations such as aphasias, apraxia, delirium, confusions and drowsiness, all depending on the amount of injury and the degree of collateral circulation. Many of these dysfunctions, intermittent, last for hours to a few days. Unless hemorrhage is profuse, or near the central cavities, the spinal fluid is as a rule normal.

During the course of the illness there develop signs of the thrombocytopenia, such as ecchymoses and hemorrhage into the skin, buccal and mucosal linings, and retina. Gross hemorrhage from the genitourinary and digestive passages is common.

The hemolytic processes produce a great degree of anemia and some retention jaundice (hyperbilirubinemia without bilirubinuria) to the skin, the degree also depending on the liver's ability to dispose of the excess pigment bilirubin. There is usually blood in the urine. Urobilinogen, though usually increased in the stool and urine, may in cases treated by chemotherapy show little increase, especially when the "mycin" antibiotics are employed. These "mycin" therapeutic agents, such as aureomycin and others, interfere with the transformation of bilirubin into urobilinogen by their effect on the intestinal flora.[10]

Differential Diagnosis

Before considering the differential diagnosis, all diagnostic criteria of the thrombocytopenia and hemolytic anemia must be satisfied. The diagnosis then narrows itself to a limited number of diseases.

The hematologist, with his specific ability to interpret bone marrow and blood cytology, will be of extreme assistance in eliminating other simulating blood dycrasias. The significance of the Coombs test and the fragility studies may well prove to be of extreme diagnostic importance.

The other essential part of the diagnostic triad is the transitory focal neurologic and mental signs.

The following more common blood diseases with thrombocytopenia and hemolytic anemia must be differentiated:

1. Leukemia. The massive and diffuse hemorrhages in cases of this disease and the acuteness of the illness always arouse suspicion. In the case herein presented, this was the hospital pathologist's first impression on differential blood count, gross autopsy, and quick microscopic study of the slides. Adequate bone marrow studies and chronologic studies of the blood should eliminate leukemia.

2. Symptomatic or secondary hemolytic anemia such as one sees in the lymphoblastomas, bone marrow invasion by malignant disease, carcinomatosis and aplastic anemia, should offer no real problem if the underlying condition is evaluated by biopsy, bone marrow studies, positive reaction to the Coombs test, and other measures. The neurologic symptoms, if they occur, are not of the transitory type.

3. Purpura and anemia due to drugs, infections, toxins, irradiation, or antibody reaction do not present the typical neurologic signs. Alertness to the history is always a diagnostic essential.

4. Familial hemolytic jaundice in the stage of crises must be considered. Here the constant spherocytosis and typical fragility test as well as the family history, including examination of the other members of the family, and the absence of focal neurologic signs should impart sufficient means for diagnostic significance.

5. Paroxysmal nocturnal hemoglobinuria. The typical history and nocturnal pattern, course, nontransitory neurologic signs, and mildness of the purpura and thrombocytopenia should suffice.

6. Acquired hemolytic anemia, classified as acute "acquired" hemolytic anemia of unknown etiology, idiopathic, usually reveals a positive reaction to the Coombs test, a mild thrombocytopenia, and only rarely neurologic signs.

There are other diseases which may tax the diagnostic acumen of the observer, such as cirrhosis of the liver, untreated pernicious anemia, idiopathic purpura hemorrhagica and sickle cell anemia, but which meticulous blood and bone marrow studies would eliminate from the criteria essential for the diagnosis of thrombotic thrombocytopenic purpura.

Prognosis

Invariably a fatal illness in one to three weeks in all proved reported cases seems to be the consensus of all investigations.

Treatment

Being more alert to the possibility of this disease, one may in the future be faced with an especially difficult problem as to therapy, if the diagnosis may be ascertained beyond doubt in the antemortem phase.

Splenectomy, although unsuccessful to date, has not been given a real trial, for in most cases this was a last desperate attempt and hope. There is no real reason at the present time for assuming that this surgical procedure should offer any therapeutic result.

The advisability of giving the anticoagulants, particularly heparin, must be considered. At present, one might be hesitant to administer these drugs in the presence of active bleeding in spite of the known fatal thrombotic encroachment of the vascular system.

The antibiotics which are usually tried in these cases, because of the resemblance to a respiratory infection at the onset, have so far proved of no value.

At present, there is no other treatment available. Supportive transfusions of whole fresh blood and palliative measures constitute the entire therapeutic armamentarium.

Report of Case

A white, married, nulliparous woman, aged 31, of Jewish descent, had been in relatively good health prior to the onset of this illness.

The past history of medical significance is as follows: Appendectomy in 1936; local resection of a fibroadenoma of the right breast in 1940; frequent sore throats, occasional headaches; gynecologic study locally and at recognized clinics for the sterility factor; at the time of her marriage five years prior to the onset of this illness, the patient bled profusely from laceration of the hymen requiring three blood transfusions and hospitalization. During the past twelve years that I have attended her, there has been nothing otherwise to suggest a hemorrhagic diathesis. The last complete blood cell count, taken on Feb. 20, 1950, was as follows: Hemoglobin, 12 Gm.; red blood cells, 4,340,000; color index 0.9; white blood cells, 12,000, polymorphonuclears, 72, segmented type 66 and stab forms 6, lymphocytes 28, nuclear index 11; platelet count normal (table 1).

Both parents, a first cousin intermarriage, and a brother were alive and well. There was no history of hemorrhagic tendencies, or of diseases that may have some hereditary foundation of transmission.

The onset of the present illness, approximately nine days before death, occurred at a time when in this city there was prevalent an epidemic of infections of the upper part of the respiratory tract. The patient became ill with fever, malaise, and severe pain in the left occipital region probably due to a thrombus in one of the adjacent blood vessels. No medication was administered except aspirin.

The second day of the illness commenced with a severe chill, the temperature rising to 104.6 F. Examination at that time revealed tenderness over the left occipital area without neurologic or dermatologic abnormalities and pharyngitis with reddening of the peripharyngeal tissues as if they had been "streaked with red paint." Because of the satisfactory response in the past to the "sulfa" drugs, within the next eighteen hours she received eight tablets, 7½ grains each, of the triple sulfonamide group, this without any therapeutic response.

On the morning of the third day, she had another severe chill, with subsequent temperature of 103 F. The headache persisted in its severity, and at this time she noted that the urine had changed its color to a blackish tint. Weakness was both subjectively and objectively evident. This, her normal menstrual period, heralded an unheeded warning in excessive menorrhagia, for until this time she had had oligomenorrhea. Therapy consisted of chloromycetin, 250 mg. every three hours.

In the past four months, the family had acquired a parrot as a pet. The parrot appeared normal, but because of the possibility of psittacosis, the bird was removed from the house and sent to a veterinarian for isolation. The patient's blood was sent to a specific laboratory for this possible diagnosis. The tube, unfortunately, was broken in transit. The parrot, however, is still alive.

Table 1

Date	Hemoglobin (Grams)	Red Blood Cells (Millions)	White Blood Cells	
2/20/50	12	4.34	12,000	Polymorphonuclears 72, lymphocytes 28. Nuclear index 10. Platelet count normal
11/12/50	4.8	1.70	14,050	Neutrophils, segmented 47, stabs 12, juveniles 3; neutrophilic myelocytes 9; neutrophilic myeloblasts 8; lymphocytes 21.
				Three normoblasts seen. Pronounced polychromatophilia, anisocytosis. Platelets markedly and seriously reduced.
				Urinalysis: Albumin 4 plus; sugar negative; red blood cells 13-14 per hpf. Casts few granular.
				Ortho-toluidine reaction strongly positive.
11/13/50	8.2	2.50		
11/14/50	10.5	3.53	23,200	Neutrophils, segmented 22, stabs 24, metamyelocytes 10, myelocytes 5, premyelocytes 3; lymphocytes 34; monocytes 2. Nuclear index 0.65. Great decrease in platelets.
				Reticulocytes 6.4 per cent. Icterus index 25. Hematocrit 30.
				Coombs test negative.

The temperature gradually subsided to 101 F. on the fourth day of the illness. The patient complained more of extreme exhaustion; her menstrual bleeding continued unabated. Petechiae were noted on the soft palate as well as in the oral mucosa; the pharnyx still appeared extremely "red painted." In addition to the chloromycetin, she also received 600,000 units of penicillin. The headache for the first time diminished. The clinical picture possessed too many ominous signs, and hospitalization was recommended.

On admission to the hospital on Nov. 12, 1950, this being the fifth day of the illness, the patient appeared acutely ill. The temperature was 99.8 F. The skin was extremely pale, and in addition to the previously mentioned petechiae, the purpuric lesions were noted on the buttocks and anterior abdomen. The liver was enlarged two fingers below the costal margin. There was profuse bleeding from the vaginal tract. Laboratory work on this date is summarized in table 1. It was the opinion of the hospital pathologist[11] that this patient had acute myelogenous leukemia. Medication at this time consisted of 1,500 cc. of blood, and the penicillin and chloromycetin antibiotics.

On the sixth day of the illness, there were associated neurologic and mental disturbances. Noted were weakness of the facial muscles on the left side and paresis of the left arm, with the patient complaining of the utter inability to coordinate the motions of this upper extremity. The urine was darkish brown in color. The liver was more tender, and enlarged. Apparently from the blood transfusions, she nevertheless appeared clinically improved. There were no fresh purpuric lesions. The antibiotics were continued, and in addition another 500 cc. of whole fresh blood was given.

The next day the face and left arm were normal. Mental confusion was evident to her family; there were periods of memory lapse, delirium, and disorientation as to time and place. It was the general opinion at this time that she had a hemolytic anemia of some nature. The sclerae appeared slightly jaundiced. She received another 1,000 cc. of blood, and the antibiotic therapy. At this time a consulting pathologist[12] made the blood analysis. His report is included in table 1. I am quoting verbatim the opinion of this pathologist, as I believe it to be of didactic value in the hematologic approach to a solution of this problem: "Unfortunately this patient had three or four transfusions of whole blood with the resulting changes before we were asked to see her. There is considerable increase in the total number of as well as a marked shift to the left in the granular cells as far as and including premyelocytes. There is also evidence of increased red cell formation as shown by the many nucleated red cells, polychromatophilia and the high reticulocyte count of 6.4 per cent, even with the dilution brought about by 3 to 4 units of transfused blood. There is also evidence of increased blood destruction as shown by the elevated icterus and the presence of free hemoglobin in the serum. The above findings together with a fair number of spherocytes on the smears point toward this condition being an acute hemolytic anemia with a leukemoid reaction. The only finding suggestive of acute leukemia is a marked reduction in platelets. However, thrombocytopenia of a rather severe grade is often found in acute hemolytic anemia. If this were in a chronic or subacute myelogenous leukemia, one would expect the platelet count to be normal or increased. A bone marrow study appears to be indicated together with red cell fragility studies, and a Coombs test. Further blood counts should be done on the peripheral blood to follow the progress of this patient, and before further blood is given."

The eighth day of the illness was unique with its many episodes of mental aberrations and confusion. At times the patient stated that she was unable to say what she wanted to say. There were no definite evidences of paralysis; however, she could not control the right upper extremity, and she complained of a heaviness of the right lower extremity. Fresh hemorrhagic bullae in the buccal membranes, petechiae and purpuric lesions of the abdomen, and a fresh hemorrhage into the retina of the right eye together with a massive hemorrhage from the gastrointestinal tract were sufficient to make the opinion of leukemia more of a threatening possibility. The heart seemed to be involved, with a protodiastolic gallop rhythm evident at the apex. To complete the hematologic

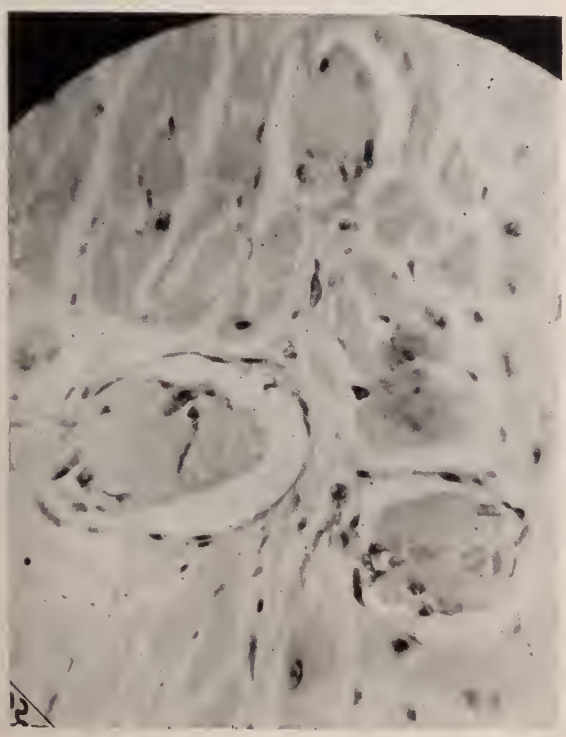


Fig. 1.—Microscopic section of the heart.

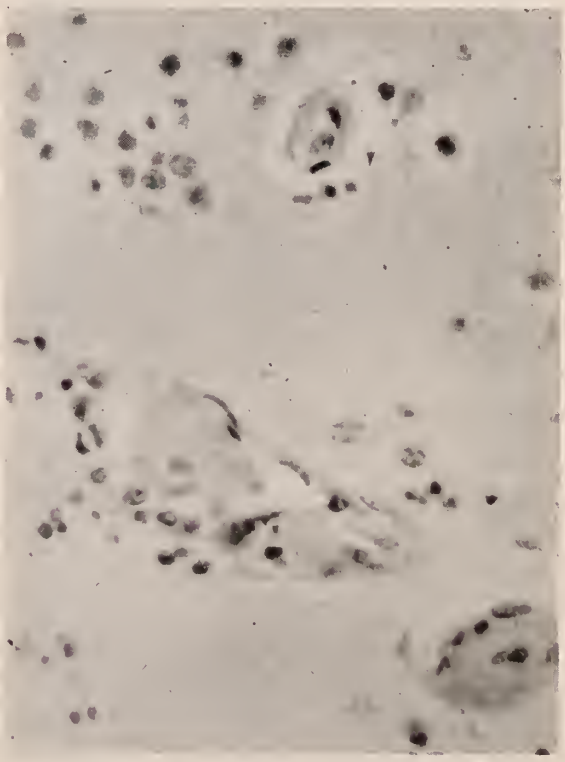


Fig. 2.—Microscopic section of the brain.

survey, the following procedures were scheduled for the morning: Bone marrow study, icteric index and Van den Bergh test, cephalin flocculation, red cell fragility, and complete blood cell count including platelet and reticulocyte counts; the Duke and Ivy bleeding test, prothrombin, Coombs test, and heparin-protamine titration. During the night she received another 1,000 cc. of fresh whole blood.

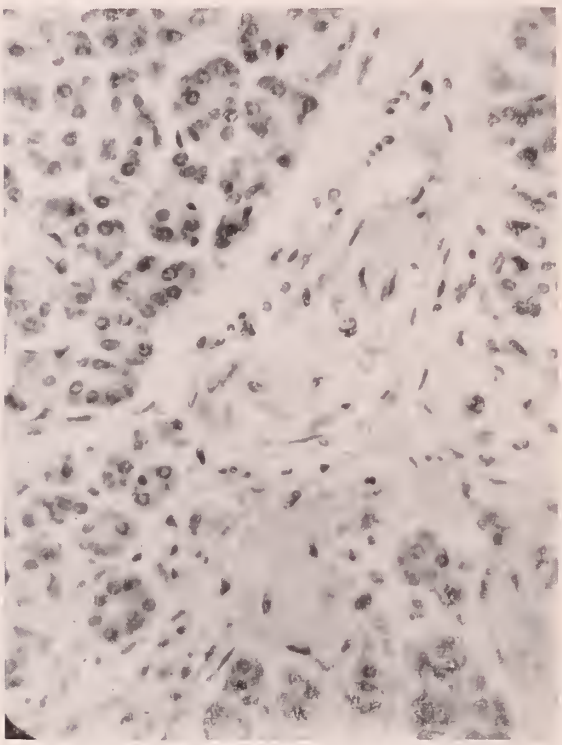


Fig. 3.—Microscopic section of the pancreas.

The following morning, the ninth of the illness, as the pathologist was preparing his needles and slides, the patient suddenly collapsed and expired. It is indeed unfortunate that the laboratory tests were not done prior to death, but due to the acute fulminating character of this illness, time did not seem to permit us to do the studies anticipated. The main problem seemed to be to replace blood, and to keep her alive. In addition to the antibiotics and blood, she received daily injections of vitamins K, C and B; orally phosphaljel and sodium bicarbonate, and sufficient fluids to maintain the electrolyte balance and body fluids. During the period of hospitalization the highest temperature was 101 F. At no time was there significant adenopathy or splenomegaly.

On gross autopsy performed approximately one hour after death, it was the first opinion of the physicians present at the autopsy that this patient had some rare form of leukemia. The consulting pathologist,[12] however, insisted that this was not a leukemia and by microscopic studies established the diagnosis of thrombotic thrombocytopenic purpura with leukemoid reaction. The diagnosis was confirmed by Dr. Karl Singer of Chicago, and the Armed Forces Institute of Pathology, Washington, D. C.

There follows a summary of the positive findings.[11] Gross Findings: The skin appeared pale, and there were a number of petechial hemorrhages and areas of ecchymosis over the dermal surfaces. The mouth showed a number of irregular ulcerated areas with hemorrhagic bases. On opening the body, 120 cc. of slightly blood-tinged fluid was found in the left pleural cavity and 250 cc. of similar fluid in the right pleural cavity. The pericardium contained approximately 300 cc. of clear yellow fluid. The myocardium was soft, and throughout the wall of the left ventricle and intraventricular septum there were numerous small hemorrhages. No free fluid was found in the abdomen. A small area of erosion was present in the lower end of the esophagus, and the entire stomach and small intestines contained large amounts of fresh blood. The colon contained darker red blood. Numerous submucosal hemorrhages were seen scattered throughout the gastrointestinal tract. There were a number of petechial and focal hemorrhages scattered throughout the brain and the renal pelves. Similar submucosal hemorrhages were seen in the bladder. The uterus and vagina contained freshly clotted blood. The sternal, vertebral and rib marrow was bright red and appeared thinner than usual.

Miscroscopic Findings: Sections of the lymph nodes, spleen, brain, gastrointestinal tract, pancreas, kidneys and heart showed numerous capillaries and small arterioles filled with deeply eosinophilic thrombi. Some of these vessels showed slight proliferation of the endothelial lining about the thrombi. The lymph nodes, liver, spleen and kidneys all showed small collections of immature cells of both myeloid and erythroid series. No thrombi were found in the sections of bone marrow, but there was a remarkable proliferation of nucleated red blood cells. These numbered about 50 per cent of the total cellular elements of the marrow. There was also a moderate increase in the immature myeloid elements. Megakaryocytes appeared normal in number. Additional findings included small areas of focal necrosis in the liver, and small scattered hemorrhages throughout the pancreas, wall of the gastrointestinal tract, brain, heart and kidneys.

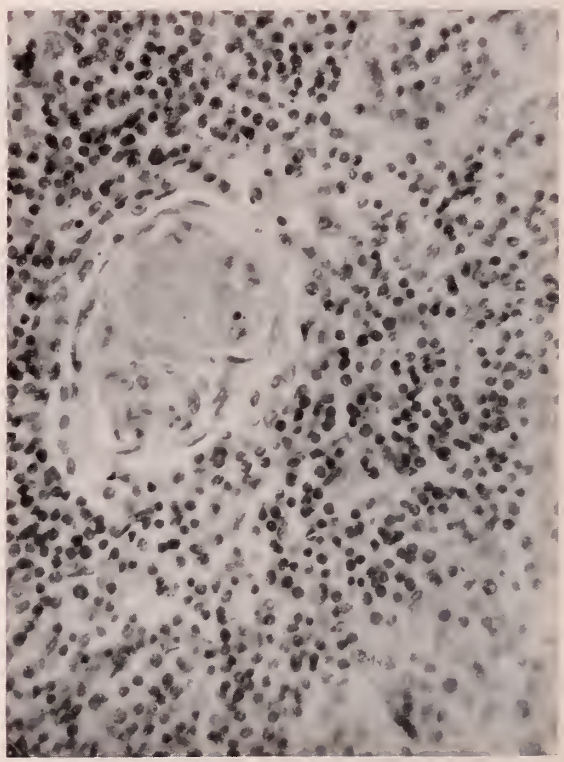


Fig. 4.—Microscopic section of the stomach.

Representative microscopic sections of the heart, brain, pancreas and stomach are illustrated in figures 1, 2, 3 and 4.

Summary of the Autopsy: Thrombotic thrombocytopenic purpura with leukemoid reaction; thromboses of capillaries, lymph nodes, heart, brain, gastrointestinal tract,

pancreas, spleen and kidneys; myeloid metaphlasia of the liver, spleen, lymph nodes and kidneys; exsanguinating gastrointestinal hemorrhage; multiple mucosal hemorrhages of the stomach and small intestine; bilateral focal pulmonary atelectasis and congestion; focal pulmonary hemorrhages; focal hemorrhages of the brain, pancreas and myocardium.

Summary

The case of a 31 year old woman here reported adds another to the too few described and confirmed cases of thrombotic thrombocytopenic purpura, a fulminating illness, febrile, with acute hemolytic anemia, leukemoid reaction, thrombocytopenic purpura, and transitory focal neurologic and mental disturbances. The literature is reviewed, and the differential diagnosis, etiology and pathologic physiology are discussed. It is hoped that with the availability of more in vito studies, this syndrome may be the more readily diagnosed, with perhaps a clinical cure resulting for this at present invariably fatal disease.

References

1. Moschowitz, E.: Acute Febrile Pleiochromic Anemia with Hyaline Thrombosis of Terminal Arterioles and Capillaries, Arch. Int. Med. 36:89-93 (July) 1925.
2. Singer, K.; Motulsky, A. G., and Shanberge, J. N.: Thrombotic Thrombocytopenic Purpura; Studies on Hemolytic Syndrome in this Disease, Blood 5:434-448 (May) 1950.
3. Engel, G. L.; Scheinker, I. M., and Humphrey, D. C.: Acute Febrile Anemia and Thrombocytopenic Purpura with Vasothromboses, Ann. Int. Med. 26:919-933 (June) 1947.
4. Schwartzman, G.; Klemperer, P., and Gerber, I. E.: Phenomenon of Local Tissue Reactivity to Bacterial Filtrates; Role of Altered Vascular Response in Certain Human Diseases, J. A. M. A. 107:1946-1951 (Dec. 12) 1936.
5. Gore, I.: Disseminated Arteriolar and Capillary Platelet Thrombosis; Morphologic Study of Its Histogenesis, Am. J. Path. 26:155-175 (Jan.) 1950.
6. Baehr, G.; Klemperer, P., and Schifrin, A.: Acute Febrile Anemia and Thrombocytopenic Purpura with Diffuse Platelet Thromboses of Capillaries and Arterioles, Tr. A. Am. Physicians 51:43-58, 1936.
7. Singer, K.; Bornstein, F. P., and Wile, S. A.: Thrombotic Thrombocytopenic Purpura; Hemorrhagic Diathesis with Generalized Platelet Thromboses, Blood 2:542-554 (Nov.) 1947.
8. Muirhead, E. E.; Crass, G., and Hill, J. M.: Diffuse Platelet Thromboses with Thrombocytopenic and Hemolytic Anemia (Thrombotic Thrombocytopenic Purpura), Am. J. Clin. Path. 18:523-532 (July) 1948.
9. Clough, P. W.: Thrombotic Thrombocytopenic Purpura, Ann. Int. Med. 33:739-743 (Sept.) 1950.
10. Sborov, V. M.; Jay, A. R., and Watson, C. J.: Effect of Aureomycin on Urohilinogen Formation and Fecal Flora, J. Lab. & Clin. Med. 34:1743-1744 (Dec.) 1949.
11. Storey, W. D., Tampa, Fla.
12. Patterson, J. N., Tampa, Fla.

608 Tampa Street.

ABSTRACTS OF MEDICAL ARTICLES

Abdominal Tumors — A Urologic Perspective. By M. M. Coplan, M.D., Frank M. Woods, M.D., P. D. Melvin, M.D. Am. Surgeon 17:1160-1167 (Dec.) 1951.

The purpose of this paper is to present a urologic perspective of abdominal masses and make known some of the diagnostic methods urology has to offer. The authors' knowledge of surgical errors that could have been prevented by proper preoperative urologic examination prompted the presentation.

Several conditions causing abdominal masses are described, and displacement of various parts of the urinary tract by intrinsic and extrinsic pathologic conditions is demonstrated roentgenologically. The authors conclude that much valuable information may be gained by a three dimensional urologic survey whenever an abdominal mass is encountered on physical examination.

Vesicular Pharyngitis, Its Relationship to the Coxsackie Group of Viruses. By J. K. David, Jr., M.D., Daniel Leavitt, M.D. and Beatrice F. Howitt. Pediatrics 8:672-677 (Nov.) 1951.

During the summers of 1949 and 1950, a number of children in Jacksonville, usually under 5 years of age, became ill suddenly with fever, malaise and anorexia. Examination revealed vesicular or aphthous lesions on the soft palate and anterior faucial pillars. The fever was of brief duration, usually less than 48 hours. The clinical course and the appearance of the pharyngeal lesions were strikingly uniform. A viral agent pathogenic for suckling mice was isolated from the throat secretions of 12 of 13 patients showing this clinical picture.

The authors concluded that the results of their study, in which the Coxsackie group of viruses was recovered from these 12 patients ill with vesicular pharyngitis, strongly suggest a causal relationship between the viral agent recovered and the clinical disease.

FLORIDA MEDICAL ASSOCIATION

OFFICERS AND COMMITTEES

OFFICERS

ROBERT B. MCIVER, M.D., President.....*Jacksonville*
FREDERICK K. HERPEL, M.D., Pres.-elect..*West Palm Beach*
FRANCIS H. LANGLEY, M.D., 1st Vice Pres...*St. Petersburg*
ERASMUS B. HARDEE, M.D., 2nd Vice Pres.....*Vero Beach*
H. QUILLIAN JONES, M.D., 3rd Vice Pres.....*Fort Myers*
SAMUEL M. DAY, M.D., Sec'y-Treas.....*Jacksonville*
SHALER RICHARDSON, M.D., Editor.....*Jacksonville*

MANAGING DIRECTOR

STEWART G. THOMPSON, D.P.H.....*Jacksonville*
ERNEST R. GIBSON, Assistant.....*Jacksonville*

BOARD OF GOVERNORS*

ROBERT B. MCIVER, M.D., Chm...(Ex Officio).*Jacksonville*
JAMES L. BORLAND, M.D...AL-53.....*Jacksonville*
DUNCAN T. MCEWAN, M.D...B-53.....*Orlando*
JAMES H. POUND, M.D...A-54.....*Tallahassee*
NORVAL M. MARR, M.D...C-55.....*St. Petersburg*
JOHN D. MILTON, M.D...D-56.....*Miami*
HERBERT E. WHITE, M.D...PP-53.....*St. Augustine*
DAVID R. MURPHEY, JR., M.D...PP-54.....*Tampa*
FREDERICK K. HERPEL, M.D. (Ex Officio).*W. Palm Beach*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*
HERBERT L. BRYANS, M.D...S.B.H.-53.....*Pensacola*
STEWART G. THOMPSON, D.P.H. (Advisory)...*Jacksonville*

*SUB-COMMITTEES

1. Veterans Care
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
GEORGE M. STUBBS, M.D.....*Jacksonville*
DOUGLAS D. MARTIN, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

2. Liaison — National Foundation Infantile Paralysis
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
A. JUDSON GRAVES, M.D.....*Jacksonville*
H. PHILLIP HAMPTON, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

3. Review of Fee Schedules
JOHN D. MILTON, M.D., Chm.....*Miami*
WOODROW B. ESTES, M.D.,.....*St. Petersburg*
FREDERICK H. BOWEN, M.D.....*Jacksonville*
ODIS G. KENDRICK, JR., M.D.....*Tallahassee*.
JAMES B. GLANTON, M.D.....*Orlando*
FLOYD K. HURT, M.D.....*Jacksonville*
HERSCHEL G. COLE, M.D.....*Tampa*
A. FRANKLIN HARRISON, M.D.....*Madison*
JACK O. W. RASH, M.D.....*Miami*
KENNETH S. WHITMER, M.D.....*Miami*
ADELBERT F. SCHIRMER, M.D.....*Orlando*

4. Blue Shield
LEIGH F. ROBINSON, M.D., Chm.....*Fort Lauderdale*

SCIENTIFIC WORK

JAMES N. PATTERSON, M.D., Chm...AL-53.....*Tampa*
CAROL C. WEBB, M.D...A-53.....*Pensacola*
FREDERICK K. HERPEL, M.D...D-54.....*West Palm Beach*
JERE W. ANNIS, M.D...C-55.....*Lakeland*
RICHARD C. CUMMING, M.D...B-56.....*Ocala*

LEGISLATION AND PUBLIC POLICY

H. PHILLIP HAMPTON, M.D., Chm...B-53.....*Tampa*
WILLIAM M. ROWLETT, M.D...AL-53.....*Tampa*
DANIEL A. MCKINNON, M.D...A-53.....*Marianna*
ANGUS D. GRACE, M.D...C-55.....*Fort Myers*
DONALD W. SMITH, M.D...D-56.....*Miami*
ROBERT B. MCIVER, M.D. (Ex Officio).....*Jacksonville*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*

MEDICAL EDUCATION AND HOSPITALS*

JACK Q. CLEVELAND, M.D., Chm...AL-53.....*Coral Gables*
JULIUS C. DAVIS, M.D...A-53.....*Quincy*
ELBERT MCLAURY, M.D...D-54.....*Hollywood*
S. CARNES HARVARD, M.D...C-55.....*Brooksville*
BENJAMIN F. DICKENS, M.D...B-56.....*Fernandina*

*SPECIAL ASSIGNMENT

1. Urge Gifts to American Medical Education Foundation

PUBLIC RELATIONS*

EUGENE B. MAXWELL, M.D., Chm...AL-53.....*Tampa*
LEIGH F. ROBINSON, M.D...D-53.....*Fort Lauderdale*
HOWARD V. WEEMS, SR., M.D...C-54.....*Sebring*
EUGENE G. PEEK, JR., M.D...B-55.....*Ocala*
HENRY L. SMITH, JR., M.D...A-56.....*Tallahassee*

*SPECIAL ASSIGNMENTS

1. Rural Educational Program
2. State Education Campaign

NECROLOGY

ALVIN L. STEBBINS, M.D., Chm...A-56.....*Pensacola*
HUGH WEST, M.D...AL-53.....*DeLand*
JOSEPH HALTON, M.D...C-53.....*Sarasota*
WALLACE H. MITCHELL, M.D...D-54.....*Key West*
JOSEPH J. LOWENTHAL, M.D...B-55.....*Jacksonville*

MEDICAL POSTGRADUATE COURSE

TURNER Z. CASON, M.D., Chm...B-55.....*Jacksonville*
ARTHUR J. BUTT, M.D...AL-53.....*Pensacola*
FRANZ H. STEWART, M.D...D-53.....*Miami*
J. BROWN FARRIOR, M.D...C-54.....*Tampa*
FRANCIS T. HOLLAND, M.D...A-56.....*Tallahassee*

CANCER CONTROL

FRAZIER J. PAYTON, M.D., Chm...D-54.....*Miami*
MILTON C. MALONEY, M.D...AL-53.....*Jacksonville*
ROBERT L. TOLLE, M.D...B-53.....*Orlando*
GEORGE W. MORSE, M.D...A-55.....*Pensacola*
WESLEY W. WILSON, M.D...C-56.....*Tampa*

MEDICAL ECONOMICS

REUBEN B. CHRISMAN, JR., M.D., Chm...AL-53....*Miami*
JOHN E. MAINES, JR., M.D...B-53.....*Gainesville*
HARRISON A. WALKER, M.D...D-54.....*Miami*
WILLIAM H. WALTERS, JR., M.D...C-55.....*Lacoochee*
WILLIAM C. ROBERTS, M.D...A-56.....*Panama City*

VENEREAL DISEASE CONTROL

MELVIN M. SIMMONS, M.D., Chm...C-55.....*Sarasota*
JOHN R. BROWNING, M.D...AL-53.....*Jacksonville*
JOHN C. MCSWEEN, JR., M.D...A-53.....*Pensacola*
WILEY M. SAMS, M.D...D-54.....*Miami*
DAVID W. GODDARD, M.D...B-56.....*Daytona Beach*

TUBERCULOSIS AND PUBLIC HEALTH*

RALPH S. SAPPENFIELD, M.D., Chm...AL-53.....*Miami*
PHILLIP W. HORN, M.D...B-53.....*Jacksonville*
ERASMUS B. HARDEE, M.D...D-54.....*Vero Beach*
LOUIS J. GARCIA, M.D...C-55.....*Tampa*
HARRY S. HOWELL, M.D...A-56.....*Lake City*

*SPECIAL ASSIGNMENT

1. Diabetes Control

STATE CONTROLLED MEDICAL INSTITUTIONS

William D. Rogers, M.D., Chm...A-56....*Chattahoochee*
James L. Anderson, M.D...AL-53.....*Miami*
Bailey B. Sory, Jr., M.D...D-53.....*Palm Beach*
James G. Lyerly, M.D...B-54.....*Jacksonville*
Samuel G. Hibbs, M.D...C-55.....*Tampa*

MATERNAL WELFARE

E. Frank McCall, M.D., Chm...B-56.....*Jacksonville*
T. Bert Fletcher, Jr., M.D...AL-53.....*Tallahassee*
Lowrie W. Blake, M.D...C-53.....*Bradenton*
John N. Sims, Sr., M.D...A-54.....*Live Oak*
Ralph W. Jack, M.D...D-55.....*Miami*

CHILD HEALTH

Luther W. Holloway, M.D., Chm...B-53....*Jacksonville*
James R. Boulware, Jr., M.D...AL-53.....*Lakeland*
Warren W. Quillian, M.D...D-54.....*Coral Gables*
Daniel F. H. Murphey, M.D...C-55.....*St. Petersburg*
Courtland D. Whitaker, M.D...A-56.....*Marianna*

CONSERVATION OF VISION

Ralph N. Greene, Jr., M.D., Chm...AL-53..*Jacksonville*
William Y. Sayad, M.D...D-53.....*West Palm Beach*
Sherman B. Forbes, M.D...C-54.....*Tampa*
G. Tayloe Gwathmey, M.D...B-55.....*Orlando*
Mozart A. Lischkoff, M.D...A-56.....*Pensacola*

ADVISORY TO WOMAN'S AUXILIARY

C. Robert DeArmas, M.D., Chm...B-55....*Daytona Beach*
Benjamin H. Sullivan, M.D...AL-53.....*St. Petersburg*
Edward F. Shaver, M.D...C-53.....*Tampa*
James L. Anderson, M.D...D-54.....*Miami*
Taylor W. Griffin, M.D...A-56.....*Quincy*

REPRESENTATIVES TO INDUSTRIAL COUNCIL*

Charles R. Burbacher, M.D., Chm...D-55..*Coral Gables*
Fred H. Albee, Jr., M.D...AL-53.....*Orlando*
G. Frederick Oetjen, M.D...B-53.....*Jacksonville*
Chas. L. Farrington, M.D...C-54.....*St. Petersburg*
Lee Sharp, M.D...A-56.....*Pensacola*

*SPECIAL ASSIGNMENT

1. *Industrial Health*

COUNCILOR DISTRICTS AND COUNCIL

Eugene G. Peek, Jr., M.D., Chm...AL-53.....*Ocala*
First—Francis M. Watson, M.D...1-54.....*Marianna*
Second—Benjamin A. Wilkinson, M.D...2-53.*Tallahassee*
Third—William C. Thomas, Jr., M.D...3-54..*Gainesville*
Fourth—Eugene L. Jewett, M.D...4-53.....*Orlando*
Fifth—Hugh G. Reaves, M.D...5-53.....*Sarasota*
Sixth—Emmett E. Martin, M.D...6-54.....*Haines City*
Seventh—Erasmus B. Hardee, M.D...7-54....*Vero Beach*
Eighth—Donald W. Smith, M.D...8-53.....*Miami*

GRIEVANCE COMMITTEE

Walter C. Payne, M.D., Chm.....*Pensacola*
David R. Murphey, Jr., M.D.....*Tampa*
Herbert E. White, M.D.....*St. Augustine*
Joseph S. Stewart, M.D.....*Miami*
William C. Thomas, Sr., M.D.....*Gainesville*

ADVISORY TO SELECTIVE SERVICE FOR PHYSICIANS AND ALLIED SPECIALISTS

J. Rocher Chappell, M.D., Chm.....*Orlando*
Thomas H. Bates, M.D..."A".....*Lake City*
Frank L. Fort, M.D..."B".....*Jacksonville*
Alvin L. Mills, M.D..."C".....*St. Petersburg*
John D. Milton, M.D..."D".....*Miami*

EMERGENCY MEDICAL SERVICE

James V. Freeman, M.D., Chm.....*Jacksonville*
Merritt R. Clements, M.D..."A".....*Tallahassee*
Vernon A. Lockwood, M.D..."B".....*St. Augustine*
Herschel G. Cole, M.D..."C".....*Tampa*
Frederick K. Herpel, M.D..."D".....*West Palm Beach*

A.M.A. HOUSE OF DELEGATES

Homer L. Pearson, Jr., M.D., Delegate.....*Miami*
Frank D. Gray, M.D., Alternate.....*Orlando*
(Terms expire Dec. 31, 1952)

Louis M. Orr, II, M.D., Delegate.....*Orlando*
Joshua C. Dickinson, M.D., Alternate.....*Tampa*
(Terms expire Dec. 31, 1953)

Herbert L. Bryans, M.D., Delegate.....*Pensacola*
Thomas H. Bates, M. D., Alternate.....*Lake City*
(Terms expire Dec. 31, 1955)

BOARD OF PAST PRESIDENTS

William E. Ross, M.D., 1919.....*Jacksonville*
H. Marshall Taylor, M.D., 1923.....*Jacksonville*
John C. Vinson, M.D., 1924.....*Fort Myers*
John S. McEwan, M.D., 1925.....*Orlando*.
H. Mason Smith, M.D., 1926.....*Tampa*
John A. Simmons, M.D., 1927.....*Arcadia*
Frederick J. Waas, M.D., 1928.....*Jacksonville*
Julius C. Davis, M.D., 1930.....*Quincy*
William M. Rowlett, M.D., Chm., 1933.....*Tampa*
Homer L. Pearson, Jr., M.D., 1934.....*Miami*
Herbert L. Bryans, M.D., 1935.....*Pensacola*
Orion O. Feaster, M.D., 1936.....*Renton, Wash.*
Edward Jelks, M.D., 1937.....*Jacksonville*
W. Henry Spiers, M.D., 1938.....*Orlando*
Leigh F. Robinson, M.D., 1939.....*Fort Lauderdale*
Walter C. Jones, M.D., 1941.....*Miami*
Eugene G. Peek, Sr., M.D., 1943.....*Ocala*
John R. Boling, M.D., 1944, 1945.....*Tampa*
Shaler Richardson, M.D., 1946.....*Jacksonville*
William C. Thomas, Sr., M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne, M.D., 1949.....*Pensacola*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey, Jr., M.D., Sec'y., 1951.....*Tampa*

From Our President

The American Way — An Evaluation

"The American Way of Life" — what is it? Merely a catch phrase become trite? Or is it to the individual citizen truly meaningful, expressive of the real America in which our forefathers saw a second chance for humanity, a free life on a new continent?

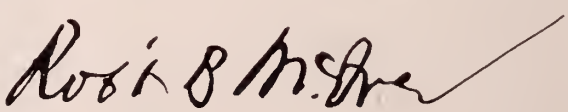
Americans abroad are finding that Europeans do not regard the American way of life as an unmitigated blessing, an altogether desirable importation like, for example, an American car. Not that they prefer Kremlin regimentation, but they point to materialism, superficiality, standardization and mass production even of ideas and literature as traits of American life which repel them. With America in the lead as a world power, our European critics take note of a complacency on our part none the less smug for being often unconscious.

That smug complacency of which our European friends and foes alike take cognizance could well be our undoing, the kind of fatal error for which proponents of foreign ideologies are watching. No group in American life today should be more aware of its dangers than the medical profession after its gruelling experiences recently in confronting the gravest crisis of its history.

"Few persons realize the distance we have traveled, as a nation, down the road to socialism," said retiring President John W. Cline to the American Medical Association at its June meeting. "As physicians we know that in the course of many diseases a point is reached where the changes of structure in the tissues become irreversible and restitution of normal function becomes impossible. The disease of socialism which affects our body politic is at the present time not far from that point.

"This may well be the year of decision. Unless the trend toward an all powerful government progressively extending its influence into our daily lives, limiting our horizons and sapping our initiative is halted, the changes in our political, economic and social structure will soon have reached the state of irreversibility. If this occurs, we will have sacrificed the most precious heritage any nation ever had, and for a mess of socialistic pottage."

Every leader of American medicine, at county, state and national level, should heartily join with Dr. Cline in urging every citizen who values the American tradition of freedom, opportunity and dignity of the individual to utmost effort this year. Let us all analyze our basic freedoms intelligently and be articulate about them. This may be our last chance to preserve those essential ingredients of the American way of life.



The Journal of the
Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. BOX 1018 JACKSONVILLE, FLORIDA

Editor
Shaler Richardson, M.D.

Assistant Editors
Webster Merritt, M.D.
Franz H. Stewart, M.D.

Associate Editors

Louis M. Orr, II, M.D. ..... Orlando
Joseph J. Lowenthal, M.D. ..... Jacksonville
Jere W. Annis, M.D. ..... Lakeland
Herschel G. Cale, M.D. ..... Tampa
Wilson T. Sawder, M.D. ..... Jacksonville
Carlos P. Lamar, M.D. ..... Miami
Walter C. Payne, M.D. ..... Pensacola

Managing Editor
Stewart G. Thompson, D.P.H.
Ernest R. Gibson, Asst.

Committee on Publication

Shaler Richardson, M.D., Chairman ..... Jacksonville
Chas. J. Callins, M.D. ..... Orlanda
James N. Patterson, M.D. ..... Tampa

Abstract Department

Kenneth A. Morris, M.D., Chairman ..... Jacksonville
Walter C. Jones, M.D. ..... Miami

The Hypertension Pendulum

In any disease in which numerous drugs are used therapeutically, usually none is specific. Hypertension with its resultant heart failure, uremia and cerebrovascular catastrophes has become the great killer of our time. During the past generation numerous drugs hailed raucously as panaceas for essential hypertension have been quietly discarded.

Although research into the etiology of essential hypertension has increased greatly during the last few decades, the true cause or causes are still essentially unknown. Various pressor and antipressor substances have been isolated from the kidney, liver and other body tissues, some of which undoubtedly occur in vivo and others just as certainly as artefacts. The variously assigned names, initials and symbols given these substances do little more than confuse the average practitioner in an atmosphere already clouded with prognostic gloom.

Physicians are by nature an optimistic group. With any new therapeutic discovery the drug is used with tremendous zeal before proper evaluation can be made. All are familiar with the immediate past eras of low sodium diets for hypertensive patients which soon fell into disrepute only to come back into vogue after the rise and decline of the rice diet. Interspersed in these eras were periods of exulting in various operations which tended to return man to his former vegetative existence by removing large segments of his nervous system. Various drugs which had been pushed into obscurity by their toxicity now have new supporters. Yet, even though these drugs are now more nearly pure, their therapeutic and toxic levels are so close, and the incidence of failure so great, as to preclude their use for most patients.

Within the past few months two new therapeutic agents have been released to physicians for the treatment of essential hypertension. Both drugs have been studied clinically for over two years and the preliminary reports, even discounting the typical enthusiasm inherent in such studies, have been most encouraging. They both are indeed hypotensive agents.

It would indeed be wise before most physicians proclaim to their patients that the hexamethonium compounds and apresoline (R) and related substances are cures for hypertension, to look back over the tombs of the veritable armamentarium of drugs used for hypertension and now buried in oblivion. It would be well to realize that neither of these new compounds attacks the cause of essential hypertension because it is extremely difficult to remove an unknown factor. It must also be stressed that while these drugs do have hypotensive actions and do lower blood pressure, an elevated blood pressure is merely one easily detectable manifestation of the many manifestations of essential hypertension. Many are the physicians who have lowered patients' blood pressures by various measures only to have the patient continue

an inexorably downhill course to death. Whether periodic lowering of blood pressure by these new agents will aid in reversing a disease whose natural history is still an enigma is still not proved.

It is not our purpose to enshroud essential hypertension with more prognostic pessimism than has already been done. Physicians, however, must realize that until the cause of essential hypertension, or the causes of the various entities which cause essential hypertension, are known, the possibility of a therapeutic agent curing this disease is practically nil. Perhaps it is good therapy in selected cases to mislead a patient, but no physician should ever allow himself to be misled by various claims and counter claims of research workers which have been embellished with the lure of manufacturing pharmaceutic companies. The temptation to use a new wonder drug is great; the desire of patients to have all new cure-alls described in various magazines given them for treatment is even greater.

Physicians must be neither mere drug dispensers nor knife wielders. Ofttimes close rapport with patients in showing them a way of life, of giving comfort and reassurance coupled with judicious sedation when needed, can give a serene existence to the hypertensive patient and allow him to lead a full life perhaps no shorter than that of the victim of a drastic surgical onslaught, or one who must put a sphygmomanometer on his arm four or more times a day, or the unhappy malnourished product of a diet faddist. The many facets of the disease we call essential hypertension still require for adequate treatment a nice integration of the whole art of medicine, including employment of the newer drugs but not to the exclusion of all else.

Medical Men and Medical Events in Early St. Augustine

Toward the end of the sixteenth century, now 355 years ago, Gonzalo Méndez de Canço arrived in St. Augustine* to take over the duties of governor for Spanish Florida. With him came a secular priest to serve as chaplain of the presidio, 24 soldiers, and 10 or 12 women "of good reputation" who were expected to become the wives of soldiers already living in the fortified little town. These newcomers found that St. Augustine was already health-conscious. At least two "barber surgeons" had located there, and a hospital was under construction when they arrived. This little hospital, the first ever designed exclusively for care of the sick within the present limits of the United States, was joined (". . . el hospital que esta agregado a la hermita") to the hermitage of Nuestra Señora de la Soledad, the Chapel of Our Lady of Solitude. That original building which served as a chapel, or another of similar architecture which replaced it, had been constructed prior to Drake's attack in 1586. Its location is indicated on the accompanying map by an arrow. The property today is owned by the St. Augustine Historical Society and is known as the Oldest House in the United States.**

Governor Canço almost immediately recognized the value of the primitive little hospital not only to the community but to the province as well. He stated that it had been responsible for saving the lives of many soldiers, Indians and Negroes who had been confined there. He appealed to the King for funds and asked that a slave in the royal services at St. Augustine be allowed to attend the sick in the hospital.

On March 14, 1599, less than two years after this first hospital had been constructed, the Franciscan monastry nearby, on the site where the state arsenal is located today, was destroyed by fire. Consequently, the friars were moved into the Chapel of the Soledad and the hospital which adjoined it. Thus for all practical purposes the hospital ceased to exist.

Recognizing the necessity for another hospital, Governor Canço soon began construction of a new building. In a letter written by him on April 24,

*Governor Canco arrived in St. Augustine on June 2, 1597.

**Validity of claims for the Oldest House has been challenged, chiefly by Mr. Charles Reynolds, historian, author and bibliophile, when he exposed some of the brashly false statements made for sites of historical interest in St. Augustine. It would seem, however, that the conscientious historian is justified in accepting the available evidence supporting the claims as strongly presumptive if not authentic. It is to be hoped that one or two weak links in the long chain of evidence will be forged later.

1601, reporting on conditions in the presidio, he referred to the hospital as that of "Santa Barbara, to which the King has made a gift."* The Santa Barbara was an institution of "decent appointments" with six beds. Constructed of "palm," it was said to have been well built. It assured the people of the little settlement "that the work of charity would not cease."

*Chatelain apparently has confused the identity of the first hospital with that of Santa Barbara.

It seems likely that the Santa Barbara Hospital was located on a marshy spot which today is near the head of Maria Sanchez Lake at the corner of St. Francis and Cordova streets, perhaps on the property of Miss Emily Wilson at 280 St. George Street. It was there that the Santa Barbara Battery was located in the mid eighteenth century, toward the end of the first Spanish period.

This is a reproduction of the Boazio map by De Bry, representing St. Augustine at the time of Drake's invasion in 1586. The Chapel of the Soledad, the building marked with an arrow, when examined with a magnifying glass appears similar in architecture to that of the "Oldest House" which stands on that site today. The first hospital in the territory which is now the United States was built in 1597 adjoining this building and was relocated there in 1605 when the Santa Barbara Hospital, built in 1599, was abandoned. The buildings to the left are those of the Franciscan monastery, which burned in 1599, the friars then taking over the first hospital for quarters. The state arsenal occupies this site today.

IX.

EXPVGNATIO CIVITATIS S. AV-
GVSTINI IN AMERICA SITÆ.

Perhaps overzealous and apparently intending to disparage and belittle his predecessor, Governor Ybarra on Dec. 26, 1605, wrote to the King:

> The hospital was built in an unhealthy locality and so very small that out of every six soldiers that entered it to get cured three would die and the other three would not convalesce. As I have now built another good church and house for those good fathers I have had the hospital moved back to the place next to the hermitage and by private contributions I have enlarged it and almost made it new over again. So that now the sick soldiers and slaves find more relief and comfort and recover much more easily — besides it is not in danger of being destroyed by fire as it was before. I intend to send to Havana for one of the Brothers of the Hospital Juan de Dios so that I may save the services of a soldier who is now [here]. This I did at the suggestion of the Council and because it was necessary. The palmetto house which formerly was used as a hospital [Santa Barbara] I ordered to be turned over to Captain Juan Garcia who is the legal representative of Gonzalo Méndez [Canço] the ex-governor. All these matters are on record as they appear in the documents which were drawn.

During these early years the little hospital, like the church, was badly in need of funds. The poor who expected to be taken care of in times of sickness gave alms for its support, and religious plays were enacted in the Chapel of the Soledad and somewhat later, it has been stated, were performed at the Royal Hospital for the benefit of

Known as the Second View of St. Augustine, this illustration is the little known and rare Dapper issue, engraved in 1671 and published at the time construction was begun on the Castillo de San Marcos. Actually the engraving probably should be titled an artist's conception of St. Augustine for there are several inaccuracies. The fort of San Marcos at no time resembled the fort as shown. It is thought that the artist mistook the Spanish word for thick forest or woods to mean hills, including them in the background. Showing much action, this engraving has always aroused interest. The boats and ships with the town in the foreground, the Indians, the Negroes at work, the cart carrying merchandise and the hurrying early American dog all bespeak lively activity. The parasol with which the Negro protects the lady from the Florida sun somewhat resembles the canopy of a Spanish four poster bed.

the sick. Just when the Royal Hospital was founded is not known. The street on which it faced was first named Street of the Royal Hospital; later, the name was shortened to Hospital Street. Finally, in 1923, when St. Augustine was given the coffin of its founder, Pedre Méndez de Aviles, the name was changed to Aviles Street. The building was located on the west side of the street, facing east, about midway between what is now King Street and Artillery Lane, where the theater is located today. It is thought that the hospital adjoining the chapel, mentioned by Governor Ybarra, and the Royal Hospital may have coexisted.

It is somewhat surprising to learn from the Bulas y Cedulas para Gobierno, dated July 3, 1573, that each Spanish town was supposed to support two hospitals. One for the poor, suffering from noncontagious illnesses, was to be built "adjoining the temple [chapel or church] with a cloister to it." The other, for those suffering with contagious diseases, was to be built on elevated ground if possible and in a region where the prevailing wind passing by it would not harm the rest of the settlement.

It is regrettable that, today, records of St. Augustine's early history are meager. There is little wonder, however, that many details cannot be found. There were hurricanes, northeasters, floods and fires. Indians frequently ambushed and attacked soldiers and citizens in the little presidio. Drake invaded the town in 1586 and virtually burned it down, leaving only church property and records. The pirate, Robert Searles, alias Davis, attacked in 1668 and took away much that was of value. Moore came in 1702, Palmer in 1728, and finally Oglethorpe laid siege to the town in 1740 and for a prolonged period fired salvos intermittently at Fort San Marcos. In addition to these frightful hazards, reports and records sent to Cuba and the Indies frequently were lost by shipwreck or capture.

During the administrations of Governor Canço, 1597-1603, and his two able successors, Ybarra and Olivera, who governed until 1612, St. Augustine presented a picture indicative of a boom, which apparently followed fire, high wind and flood in 1599. Canço described the town as having ". . . much public adornment of temples, of yglesie mayor [the parish church], the convent of San Francisco, the hospital, the hermitage of San Sevastian," and more than 400 Spanish people. Yet in those relatively good times, ample food and nourishment sometimes became a problem for the governor to solve. The illness of Father Lopez, in 1602, brought to the attention of the public the fact that some of the friars were receiving insufficient rations. Two physicians of the presidio who attended Father Lopez declared before Governor Canço that the 3 reales allotted him daily were entirely inadequate for "the good friar" needed fowl and much else. They reminded him that one chicken cost 8 reales. The governor declared that because of his faithfulness and great service, Father Lopez henceforth would receive 10 reales daily for purchase of food.

When Diego de Robelledo, the first really able and conscientious governor at St. Augustine for more than 40 years, took up his duties in 1655, the town presented a gloomy picture. The system of subsidies from New Spain had become completely disorganized, the English had taken over Jamaica, and the Dutch were reported to have visited the Spanish frontier fort in Apalache. The inhabitants and many of the Indians had suffered from smallpox for 10 months and could not work. All the Negro slaves had died. The people were nearly desperate because of hunger.

Robelledo, at the beginning of his administration, recommended, as had other governors before him, that work be started immediately upon a stone fort, and he made specific, emphatic recommendations for its accomplishment. The defenses were crumbling, the garrison had degenerated to less than 150 effective soldiers, the physical appearance of the town had deteriorated, the navy had declined to a point where there was hardly a vessel able to make the trip to Havana for provisions, much less any which could engage the English or Dutch in combat. Yet despite the clear warnings of what was in store for Spanish Florida if conditions did not improve, the colonial ministers continued to vacillate, and even when orders were issued to New Spain to pay the situado, many excuses were made for failure to do so. In a word, St. Augustine, slightly less than a century after its founding by Méndez, had been reduced to a shadow of its earlier strength, while military, social and political conditions had reached their lowest ebb. Religious activity in the presidio continued apace, but that was marred by dissension and quarrels between the missionaries on the one hand and the governor on the other, they having accused him of exploiting and torturing the Indians.

Thus it was that Robelledo in his letter to the King on Oct. 24, 1655, predicted that if payments of subsidies for the presidio were not continued, it

would perish because of the barrenness of the land. He mentioned his illness and stated that he was "without remedy, for lack of a doctor" to attend him. In 1659, he died in office.

In 1662, a report from the Council of the Indies quoted letters from Robelledo written just before his death and from Aranques y Cotes, the governor who succeeded him, to show the plight of the colony. This report made it known that 10,000 Indians, and many soldiers of the garrison at St. Augustine, had died of the plague (smallpox).

Two events having medical significance occurred at this time which brought about a major change of policy on the part of Spanish authorities concerned with the presidio. The first was the sack and partial destruction of St. Augustine by the English pirate, Robert Searles, in 1668, and the second was the establishment by the English of the first settlement in what is now South Carolina, at Charleston in 1670.

In a decree from Mexico dated Nov. 16, 1668, based largely on a report from Governor Francisco de la Guerra, it was pointed out that while there should have been 300 men in the dotacion of St. Augustine not counting the curate, chaplain of the fort, surgeon, barber, "apothecar," and captains, pilots, sailors and cabin boys of vessels, actually those available for military duty came to only 130, and 25 of these were in the garrison at Apalache. In addition, it was related that a French surgeon, who had served in St. Augustine for six years, wrote and induced the enemy to make the invasion, pointing out that there was a lack of adequate defense for the town. The enemy apparently had seized two Spanish boats off the coast of Cuba, descended without warning, made it appear that a Spanish crew manned each vessel, entered the port at midnight, sacked the presidio "without sparing the main church, the monastery of San Francisco, the hospital and other hermitages," and killed 60 people. Almost everything of value that could be "carried away" was taken to the boats. The pirates then took soundings in the harbor and the inlet and declared that they would return.

With the buccaneer, Searles, as he left the port, there sailed an amazing young doctor named Henry Woodward, who for several months had been imprisoned in St. Augustine under somewhat strange circumstances. Apparently born in the Barbados about 1646, this young "chirurgeon" had accompanied the explorer, "Robert Sandford, Esq. Secretary and Cheife Register," when he sailed from Cape Fear in what is now North Carolina, using a "smaler shallope of some three tonns" and a "vessell whose burden alsoe exceeded scarce fiveteen tonns" for a "Voyage of Discovery" farther south to Port Royal in 1666. Sanford wrote: "Henry Woodward . . . had before I sett out assured me his resolucon to stay with the Indians if I thinke convenient . . ." Apparently it was convenient, for when Sandford returned to Cape Fear, he left the young doctor, having first given him "formall possession to the whole country to hold as tennant att will of the right Hono'ble the Lords Proprietors" of Carolina. Woodward remained "some considerable time amongst the natives of those parts being treated with the greatest love and courtesye that their rude natures were acquainted withal, until the Spaniards having notice of his abode at St. Helena carried him thence to St. Augustine. . . ."

There in the little presidio the talented young doctor served as a "willing prisoner." He charmed the Spanish people and ingratiated himself with the authorities, all the while gathering information concerning their customs and storing knowledge of the town's plan and defenses. He lived for a while with the parish priest, professed Catholicism, and served as an official surgeon for the presidio. After he escaped with Searles in 1668, he was shipwrecked at Nevis, but later took passage with the Carolina fleet and not long afterward was back with the Carolinians, this time in the new settlement at Charleston.

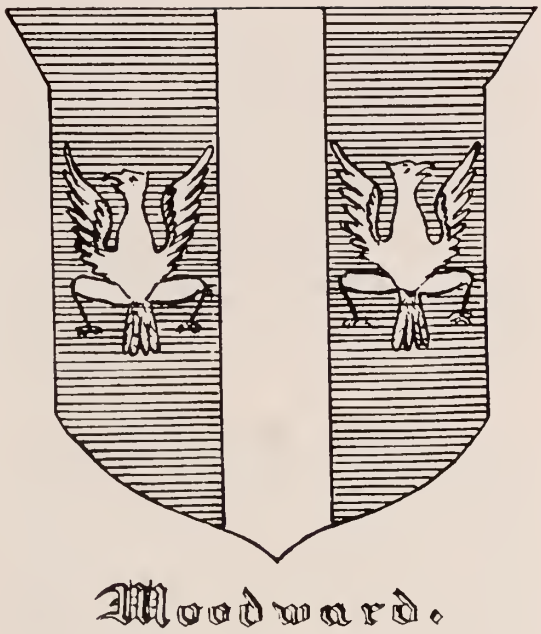
Appropriately called "a man of destiny," Dr. Woodward was able so skillfully to use the information concerning the affairs of the Spaniards, as well as his knowledge of the Indians gathered earlier, that he became the leading exponent of the arts and skills of border intrigue and made himself the most influential and powerful person in that province. He seems to have done more than any other Englishman to induce the Indians to sever their allegiance to the Spaniards, and thus almost singlehandedly was responsible for breaking Spanish control of the Florida frontier.

Distinguished pioneer of South Carolina, Dr. Woodward, whose coat of arms is here reproduced, could doubtless claim as remarkable an assemblage of eminent descendants as any American. The imposing list includes three governors of his state and three attorney generals, four senators and six representatives in the Congress of the

United States, two generals and four colonels serving in the War Between the States, two commanders of Fort Sumpter in that war, one prominent naval officer of a later period, four judges, four bishops, a noted Baptist minister, a poet, a millionaire philanthropist, the South's most outstanding cotton merchant, an editor of distinction and several authors. Not the least among the authors is one physician, Dr. William Hayne Simmons of St. Augustine, selected as one of a committee of two to locate the capital of Florida in 1822.

Physicians of Florida today salute Dr. Henry Woodward, first citizen of South Carolina. His was a unique role in the medical history of Florida during the early Spanish period.

As a result of these two events, the Castillo de San Marcos was begun in 1672 and was substantially finished 15 years later, in 1687. Thus it was that the stone age was introduced at St. Augustine, converting that bastion from one of the weakest to one of the strongest outposts in the New World. Thereafter, the little town in Northeast Florida assumed a new and more important role in the scheme of imperial defense designed to preserve the West Indies for Spain.



Coat of Arms of Dr. Henry Woodward.

The Editors wish to thank Miss Emily Wilson, resident of St. Augustine since 1892, and Mrs. Marion Moulds, acting librarian of the St. Augustine Historical Society, for making source material available and for generous help in its interpretation.

Road Slaughter

Next month brings Labor Day and another long weekend. Immediately one thinks of the inevitable and shocking accident toll that has come to be the outstanding news feature of American national holidays.

The mails are filled these days and the nation's doorsteps are littered with insurance accident plans. One on the Editor's desk at the moment warns: "Your Chances This Year are 1 in 9 you will be a hospital patient, 1 in 17 you will be disabled in an accident, 1 in 7 it will be in traffic, 1 in 2 it will be at home; there will be 1 disabling injury in every 4 families; every 3 families will average 1 hospital admission; every fifth admission will be an accident case." These figures are not too reassuring to life and limb for anyone who has escaped so far during 1952.

In a recent address published elsewhere in this issue of The Journal, Dr. Hugh A. Carithers of Jacksonville reported that accidents among Florida children are the leading cause of death. He added that motor vehicle and other transportation accidents are the chief cause of mortality from accidents among the children of the state and he stressed that accident prevention must become a responsibility of all who deal with children.

As of September 4 of last year, according to the Military Surgeon,[1] there was recorded the millionth death, in Korea, from war causes among our military forces "since the first Minute Man fell in the Battle of Lexington on April 19, 1775." During the 176 years elapsing between those dates, a state of war existed for about 30 years. This same source states that less than 52 years ago, a New York man stepped off a street car into the path of an automobile and became the first fatality from such a cause. On Dec. 22, 1951, less than four months after the historic military fatality in Korea, the millionth traffic death occurred. In round numbers, a record of 100 deaths a day has been maintained in recent years, some 35,000 a year. In the period January to November 1951, the rate per hundred thousand from enemy action was 6.3 and from motor vehicles 15.4.[2]

It is no wonder that the New York State Journal of Medicine[3] was tempted to speculate concerning the relative inefficiency of military mayhem when contrasted with the motor vehicle as a weapon of destruction. Citing an increase in population since the end of World War II by about 15,800,000 to a total of 155,800,000 at the end of 1951, this journal comments further that such increase merely indicates more potential victims and more senseless waste of human resources unless something effective is done to reduce the highway holocaust.

The National Safety Council lists speeding, drinking and driving, driving on the wrong side of the road, and failure to respect the right of way as the chief causes of traffic accidents. How to cope with the mounting problem is a question in every state, particularly in a year round vacation state like Florida. Education for safe driving may help some, but as yet comparatively little effort has been made in that direction. Giving wide publicity to the appalling accident figures may be useful, but highway bloodshed takes place as scattered incidents and does not arouse public indignation. The Military Surgeon proposes a change in the mechanism of all motor vehicles limiting the maximum speed to 50 miles an hour. Concurring in this suggestion, the New York State Journal of Medicine adds a further plea for moderation in the use of alcohol. Perhaps some way will be found eventually to hold our highway fatalities at least to the level of our battlefield casualties.

1. Mil. Surgeon 11:135 (Feb.) 1952.
2. Statist. Bull. Metrop. Life Insur. Co., December 1951.
3. New York State J. Med. 52:818 (April) 1952.

Side Entrance Technic

One naturally locks the front door. Too, it is natural to be particularly careful about barring the back door. It is easy enough, however, to overlook the side door that is less often used and more easily neglected. The would-be socializers in Washington, it appears, are fully cognizant of the side entrance technic and not above using it.

A case in point is the attempt to sneak in through the side door when H. R. 7800 was recently presented to the House of Representatives. It offers an excellent example of the need for being constantly watchful for legislation appearing beneficial at first glance, but actually on careful reading constituting an oblique approach to the control desired by the proponents of compulsory health insurance.

This omnibus bill would provide a variety of amendments to title 2 of the Social Security Act, as amended, which deals with Old Age and Survivors' Insurance benefits, including increased benefits to Old Age and Survivors' Insurance beneficiaries.[1] The objectionable feature is the section on total permanent disability, which carries with it medical determinations under the direction and control of the federal government.

Introduced on May 12, 1952, and referred to the House Committee on Ways and Means, the bill was not available in printed form until May 14. The committee gave the bill immediate consideration and reported it favorably on May 16 without public hearings and with the request that it be acted on on Monday, May 19, under a suspension of the rules, thus preventing free debate and introduction of amendments. The American Medical Association immediately registered strong protest against section 3 of the bill. On the scheduled date it was defeated when 140 of the 290 present voted against suspension of the rules.

It should be made entirely clear that the opposition of the American Medical Association and the congressmen who voted against passage of H. R. 7800 under a suspension of the rules was based on section 3 only of the bill, which would establish a dangerous precedent and would vest in the Federal Security Administrator immediate control over a large segment of the population and the medical profession. It was also based on the device adopted by its proponents. A large number of the congressmen who voted in the negative were as much opposed to the way in which the measure was presented as they were to the substance of the questionable section. Railroading a bill through committee without public hearings and then endeavoring to ram it through on the floor of the House under a suspension of the rules surely constitute an undemocratic procedure and one to which there would hardly be need to resort, especially in a bill of this nature, unless an attempt were being made to slip in through the side entrance a proposal in public disfavor.

After certain amendments had been made, the House on June 17 by a vote of 361 to 22 passed H. R. 7800 under a special procedure. Thus congressmen were obliged to vote for the bill in its entirety or deny increased social security benefits to some 4,500,000 beneficiaries. The changes, however, did not eliminate the entire section on total and permanent disability as sought by the American Medical Association.

The Senate Finance Committee eliminated the controversial disability section of the measure, and on June 26 the Senate passed the bill. On July 5, the House and Senate adopted compromise legislation, thus clearing the bill for Presidential approval. Section 3 was revised to retain a waiver of premiums and to provide medical determinations of permanent and total disability at the state rather than the federal level. This section, however, is wholly inoperative as it expires June 30, 1953, the day before applications for benefits could be received, but the new Congress could hold hearings next year and draft amendments before the effective date. Thus, in effect, final decision on this controversial question is postponed until next year.

The devious tactics resorted to in this instance serve as a timely reminder that there is no surcease in the battle with the would-be socializers. Successful defense of freedom and of sound health procedures in the past does not permit the profession to rest on its laurels; it must remain ever on the alert, not alone for frontal attacks or a stab in the back but also for the flank approach. No longer "an ideal whipping boy for any demagogue who wished to make a rabble rousing speech," American medicine must remain the significant force in American life it has become.

1. The Side Door to Socialism, editorial, J. A. M. A. 149:574-575 (June 7) 1952.

Posthumous Award to Howard Blakeslee

Howard W. Blakeslee, Associated Press science editor, who passed away on May 2 at the age of 72, was awarded posthumously on June 11 the A. M. A. Citation for Distinguished Service. The award was created in 1948 by the Board of Trustees and was on this occasion bestowed for the second time. The citation is conferred on "persons not of the medical profession . . . who have by their cooperation and aid in the advancement of medical science, medical education or medical care contributed to the achievement of the ideals of American medicine."

No more fitting choice could have been made than this distinguished layman who had served long and well to advance the ideals of medicine in this country. In the tribute paid him, this "science writer of fine competence and high integrity" was described as a friend of the American Medical Association and the profession generally. "He was loved by doctors because, in a long newspaper career, 25 years of which were devoted to science writing, Howard Blakeslee never betrayed a confidence. And, above all, his stories about medicine and medical research were accurate. He earned this highest tribute that can be paid to a medical science writer."

Many honors were his for his achievements in the field of science reporting, including the Pulitzer Prize for Reporting in 1937. Appropriately it was said of him: "Our nation offers no more striking example of the hope and promise of this country to an industrious, intelligent youth, bent on a newspaper career, than is presented in the life of this distinguished AP writer. The heritage he left among the men of science is an everlasting tribute to his memory."

A. M. A. Convention Big and Busy

The American Medical Association held the Chicago spotlight in June. Its 101st annual session was described as big in every sense of the word and busy, too. In retrospect, it was suggested that its theme might well have been taken from Emerson's "American Scholar:" "We will walk on our own feet, we will work with our own hands, we will speak our own minds." All America might well adopt such a slogan in these times and put it into action, as the doctors set about doing in their official actions.

The total official attendance exceeded 28,000, about half being physicians and the remainder being relatives, guests and technical exhibitors. Visitors from more than 40 countries, representing six continents, joined with members in calling this session "The World Fair of Medicine." As always at a "headquarters" meeting, the visitors enjoyed warm A. M. A. hospitality both at the home office and half a mile away at the mile-long Navy Pier, which housed more than 300 medical exhibits, and 375 technical exhibits, the latter requiring more than two miles of space. Some 400 scientific papers were presented.

More than 100 science writers and reporters, representing the nation's major wire services, newspapers, magazines and publishing houses, covered the news of the convention. It was estimated that 30 million Americans watched each of the special one-half hour telecasts, entitled "March of Medicine," which originated directly from the A. M. A. session and were sent out coast to coast over 39 NBC stations. For the first time an operation was televised on a nationwide hook-up.

Over 200 ABC and Mutual network stations in the United States, Hawaii and Alaska carried the inaugural address of the new president, Dr. Louis Hopewell Bauer, cardiologist of Hempstead, N. Y. Always a hard, imaginative, intensive worker, this pioneer in aviation medicine and recipient

of many honors for his broad services to his profession comes worthily to assume a well deserved place as leader of the medical profession of the nation. In his statesmanlike inaugural address Dr. Bauer asked one particularly pertinent question: "Some of medicine's critics have said, rather naively, that politics is a dirty hands business, and physicians, who belong to a clean hands profession, should not enter it. How, I ask you, can politics be anything but dirty if those with clean hands stay out?"

Retiring President John W. Cline of San Francisco was the nation's No. 1 air traveler during his year of office, covering more than 130,000 miles and delivering 84 speeches. Dr. Edward J. McCormick of Toledo, Ohio, was chosen president-elect. Dr. George F. Lull of Chicago was re-elected secretary. Dr. James R. Reuling of Bayside, N. Y., is the new speaker of the House.

Boston heart specialist, Dr. Paul Dudley White, internationally known physician, teacher and investigator, made a flying trip to Chicago to accept the 1952 Distinguished Service Award of the American Medical Association for his work in cardiology. Dr. Herbert McLean Evans of Berkeley, Calif., was recipient of the $5,000 Passano Foundation Award for his many contributions in the fields of nutrition and endocrinology.

This year's Clinical Session of the American Medical Association will be held in Denver, the 1953 session in St. Louis, and the 1954 session in Miami. Boston was selected as the site for the 1955 Clinical Session. The 102nd annual meeting has been scheduled for New York City June 1-5, 1953.

Representing the Florida Medical Association were its three delegates: Dr. Louis M. Orr, II, of Orlando; Dr. Frank D. Gray of Orlando (alternate for Dr. Homer L. Pearson, Jr.) and Dr. Herbert L. Bryans of Pensacola. Dr. Pearson was appointed to succeed himself on the Judicial Council. Dr. Bryans served as a member of the reference committee on Section and Section Work.

Registration

Total registration of Association members at the 1952 annual meeting in Chicago was 112. Members in attendance were:

BAY PINES: Edward I. Melich. BRADENTON: Lowrie W. Blake, Willis W. Harris, Roderic O. Jones, Willett E. Wentzel. COCOA: Thomas C. Kenaston. CORAL GABLES: Jack Q. Cleveland, Frank W. Hewlett, C. Howard McDevitt, Jr., Frederick P. Poppe, William P. Smith, William L. Wagener, Jr. DANIA: Fred E. Brammer. DEFUNIAK SPRINGS: Charles J. Roehm. FERNANDINA: Henry B. Dickens, Jr. FORT LAUDERDALE: Burns A. Dobbins, Jr., Paul W. Hughes, Richard A. Mills, Francis D. Pierce, George M. Rhodes, Jr., Leigh F. Robinson, Vincent V. Smith, Scottie J. Wilson. FORT PIERCE: Lester L. Whiddon. GAINESVILLE: Alva T. Cobb, Jr. HIALEAH: Eli Galitz, Charles L. Shalloway. HOLLYWOOD: Bernard Milloff. HOMESTEAD: Joseph M. Burton. JACKSONVILLE: Jackson L. Allgood, Jr., Gordon H. Ira, Thomas H. Lipscomb, Clarence D. Rollins, Clarence M. Sharp, Wilson T. Sowder. LAKE WORTH: James T. Hardy. LARGO: Helen I. Grove. MIAMI: Morris H. Blau, Orlon V. Carr, Jr., Reuben B. Chrisman, Jr., Francis N. Cooke, Milton M. Coplan, Carl H. Davis, M. Eugene Flipse, Forrest H. Foreman, Hollis F. Garrand, Maurice M. Greenfield, Robert M. Harris, Morris E. Kuckku, Carlos P. Lamar, Louis Lemberg, George D. Lilly, James K. McShane, John D. Milton, E. Sterling Nichol, Russell K. Nuzum, Homer L. Pearson, Jr., Edwin P. Preston, Maurice Rich, Hunter B. Rogers, Lyle W. Russell, George F. Schmitt, Jr., Donald G. Stannus, Richard F. Stover, Herbert W. Virgin, Jr. MIAMI BEACH: Rudolph E. Drosd, Emmett T. Fitzpatrick, Meyer J. Glick, Isidore M. Greenberger, Valentine E. Jenkins, Bernard S. Kleinman, Leo M. Levin, Alexander Libow, Maurice J. Rose, Efton J. Thomas. MIAMI SPRINGS: Clyde T. Thompson. OCALA: John J. Cheleden. ORLANDO: Frank D. Gray, Meredith Mallory, Sr., Louis M. Orr, II. PALM BEACH: Oscar L. Kelley, Joseph R. West. PENSACOLA: Herbert L. Bryans, Arthur J. Butt. ST. PETERSBURG: William C. Beach, Harry R. Cushman, Abraham J. Gorday, William E. Kendall, Peter B. Kersker, Joseph W. Pilkington. SANFORD: Thomas F. McDaniel. SARASOTA: Joseph Halton, A. George Meister, Melvin M. Simmons. SEBRING: Leldon W. Martin, Zaven M. Seron. TALLAHASSEE: Louise A. Box, Robert H. Hutchinson, Wm. E. Westcott. TAMPA: Joshua C. Dickinson, H. Phillip Hampton, Alfonso F. Massaro, Richard C. Rodgers, Hawley H. Seiler, Burdette Smith. VENICE: Talmadge S. Thompson. WEST PALM BEACH: Robert V. Artola, Theodore Norley, Herman G. Rose, Raymond S. Roy, Murray D. Sigman. WINTER PARK: Frank W. Nickel.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Arthur L. Hardie, Jr., of Jacksonville announce the birth of a son, Bradley Steven, on May 21, 1952.

Dr. and Mrs. Charles W. Folsom of Coral Gables announce the birth of a son, Charles Walton, Jr., on May 28, 1952.

Dr. and Mrs. Paul N. Unger of Miami Beach announce the birth of a daughter, Kathryn Marsha, on May 30, 1952.

Dr. and Mrs. James H. Mendel, Jr., of Miami announce the birth of a daughter, Heidi Lynn, on June 4, 1952.

Dr. and Mrs. John H. Tanous of Miami Beach announce the birth of a daughter, Jean, on June 4, 1952.

Deaths — Members

Coogler, Adrian C., Brooksville ..... June 18, 1952
Logie, Arthur J., Miami ..... June 20, 1952
Brantley, James W., Grandin ..... June 1952

Deaths — Other Doctors

Faletti, Anthony J., Miami ..... Jan. 4, 1952.
Dudley, Ervin F., Okeechobee ..... June 15, 1952

STATE NEWS ITEMS

Dr. A. Buist Litterer of Miami has returned to his practice after attending the symposium on dermatology and syphilology held at New York University Postgraduate Medical School.

Dr. Frederick K. Herpel of West Palm Beach spoke on medicine, its various aspects, including history and socialized medicine, at a recent luncheon meeting of the Palm Beach Rotary Club.

Dr. Russell B. Carson of Fort Lauderdale was speaker at a recent monthly meeting of the Broward County division of the Licensed Practical Nurses Association.

Dr. Grover C. Collins of Palatka has returned to his practice after taking a special postgraduate course at the American College of Physicians.

Dr. Leonard G. Rowntree of Miami Beach has donated his personal medical library of more than 600 books to the University of Miami's newly established medical school.

Dr. Frank G. Slaughter of Jacksonville spoke at a recent meeting of the Civitan Club of that city.

Dr. Egbert V. Anderson of Pensacola outlined the importance and necessity of a child guidance clinic in Pensacola at a meeting held at the Chamber of Commerce. Dr. Frances E. M. Read of Jacksonville, formerly of the Florida State Board of Health, spoke on the budget for such a clinic.

Dr. Carlos P. Lamar of Miami was one of the speakers of the first Interamerican Conference on Gastroenterology, Mexico City, May 11-17. The Conference was devoted to Pancreatic Pathology, and Dr. Lamar's subject was "The Control and Management of Diabetes Mellitus in the United States."

Dr. J. Rocher Chappell of Orlando has returned to his practice after attending several hospital conferences in Florida at which he was a speaker.

Dr. Donald W. Smith of Miami has been elected president of the Florida Association of Blood Banks, and Dr. John T. Stage of Jacksonville is vice president.

Dr. Edward W. Mencher of Miami Beach spent July in New York where he took a summer course in cardiology and a review course in general medicine at New York University Postgraduate Medical School.

Dr. Sidney Davidson of Fort Worth spoke on the Florida climate and heart disease at a recent meeting of the South Palm Beach Lions Club.

Dr. Henry M. Stern of Lakeland is taking a year's postgraduate work in surgery at Touro Infirmary, New Orleans.

Dr. L. Washington Dowlen of Miami spoke before the Junior League in June in cooperation with the American Cancer Society.

Practical public relations technics are included in two illustrated booklets which the American Medical Association is making available to physicians. One, a brief guide for secretaries, is being sent to all members. The other, a training guide for girls interested in becoming medical secretaries, will be available through the Florida Medical Association office.

Dr. Harry E. Beller of Miami spoke on "Rehabilitation of the Multiple Sclerotic Patient," at the Roosevelt School in June.

Dr. Samuel G. Hibbs of Tampa has been elected president of the Tampa Chapter, American Red Cross.

Dr. Albert L. Ward of Port St. Joe has been appointed by Governor Warren as a member of the Florida State Board of Health, succeeding Dr. Mark F. Boyd of Tallahassee.

Dr. C. Howard McDevitt, Jr., of Coral Gables welcomed the 16 medical and premedical students, representing 10 schools, who were guests at the Dade County Medical Association's June meeting. These and all other visiting and local medical students are urged to attend the remaining summer meetings.

Drs. Marshall E. Smith of Tampa and Robert V. Artola of West Palm Beach attended postgraduate courses at the Cook County Graduate School of Medicine in June.

Dr. David Sloane of Orlando announces the opening of his office at 724 Magnolia Ave. He will limit his practice to orthopedic surgery.

Dr. Henry B. Cordes of Frostproof was honored recently for 32 years of service to the community. Almost everyone in Frostproof turned out for the giant outdoor party in his honor. Dr. Cordes was presented a new medical bag in which was a $1,000 Defense Bond, purchased from donations made by his friends.

Also honored recently was Dr. Harry K. Morrison of Leesburg, who has given 44 years of service to that community. Dr. Morrison who, it is estimated, has delivered nearly 3,000 babies, was presented with a memory book, containing signatures of over 1,500 of the children he delivered, along with clippings and mementos of the occasion, and a new television set for his home.

Dr. Joshua M. Price of Live Oak was presented with an Honor Award Citation and Plaque at the Spring Convention of the Pine Temple Log Rollers Association of the Lake City District, Woodmen-of-the-World recently.

Dr. Herbert R. Mills of Tampa was honored recently when the Tampa Bird Club dedicated to him a dogwood tree planted on Towhee Trail, Lowry Park. Dr. Mills is one of Florida's foremost conservationists and his personal contributions have gone far toward establishing protected areas for birds in the Tampa Bay area.

Dr. Joseph D. Brown of Fort Myers was guest speaker at a meeting of District No. 7, Florida State Nurses' Association recently.

Dr. William L. Musser of Keystone Heights stressed the importance of vocational training for Florida's mentally retarded children in a talk given to the Keystone Heights Rotary Club in June.

Dr. Ralph Herz of Key West spoke on "Are You Emotionally Mature?" at a meeting of the Alcoholics Anonymous of that city.

Word has been received of the death of Dr. Olin West, 78, on June 19 in Nashville. At the time of his retirement on April 1, 1946, Dr. West had been secretary and general manager of the American Medical Association for more than 23 years.

Each member has received directly from the American Medical Association a pamphlet titled, "Your Money's Worth in Health." This pamphlet gives an attractive, readable presentation of the percentage of today's dollar which goes for medical, hospital and drug bills. Designed principally for lay readers, it is a valuable addition to the literature in a doctor's reception room. Additional copies may be obtained by writing to Box 1018, Jacksonville.

The president has signed into law a bill to continue the $100 a month special pay for physicians in military service. He also signed a bill which authorizes commissions for women physicians in the regular medical corps of the three services. The immigration bill which was passed over the president's veto gives preferential consideration to physicians and other highly skilled persons.

Dr. Lawrence E. Geeslin of Jacksonville attended the first International Diabetes Federation meeting in Leyden, The Netherlands, July 7-12.

The House of Delegates of the American Medical Association officially abolished fellowship in the Association at its June sessions in Chicago. Provision has been made for service, affiliate and honorary fellowships to be incorporated in the membership classification. All candidates in these categories for membership in the Association will be screened by the Judicial Council prior to acceptance.

The American College of Chest Physicians held its eighteenth annual meeting in Chicago June 5-8. Dr. M. Jay Flipse of Miami is a member of the Board of Regents and Dr. Clarence M. Sharp, Jacksonville, is a member of the Board of Governors.

Association members registered at the meeting included:

CORAL GABLES: Jack Q. Cleveland, William C. Phillips, Edwin P. Preston. FORT LAUDERDALE: Richard A. Mills. HOLLYWOOD: Bernard Milloff. JACKSONVILLE: Gordon H. Ira, Clarence M. Sharp. LAKE WORTH: James T. Hardy. MIAMI BEACH: Alexander Libow. MIAMI: E. Sterling Nichol, Maurice Rich, Hunter B. Rogers. ST. PETERSBURG: Arthur J. Bieker. TAMPA: Hawley H. Seiler.

The Florida Medical Association has been invited to participate in two Farm and Home Institute meetings July 24-25 and August 28-29 as part of the Rural Educational Program, according to Dr. Eugene B. Maxwell of Tampa, chairman of the committee on public relations.

The Institute is sponsored by the Agricultural Extension Service of both state universities and brings together farmers and their families from the northern part of Florida. The meetings are being held at Camp Timpoochee, near Panama City, and at Camp Cherry Lake, near Madison.

Two physician speakers have been requested for half hour medical programs on July 25 and August 29. Dr. William C. Roberts of Panama City, has accepted the invitation to appear before the group meeting July 25.

Dr. H. Phillip Hampton of Tampa has been appointed by President McIver as chairman of the Committee on Legislation and Public Policy replacing Dr. Eugene G. Peek, Sr., who recently resigned.

Dr. James V. Freeman of Jacksonville has been appointed chairman of the Committee on Emergency Medical Service by the President. He succeeds Dr. James L. Borland who resigned.

COMPONENT SOCIETY NOTES

Bay

At a recent meeting of the Bay County Medical Society, Capt. Ray Nixon explained atomic warfare and its medical implications. Capt. Nixon, a medical officer in the U. S. Air Force Reserve, based his lecture largely on material presented in the Army-Air Force short course, "Medical Aspects of Nuclear Energy," which he attended at Walter Reed Hospital, Washington, D. C.

The Bay County Medical Society has paid 100 per cent of its state dues.

Dade

At the July meeting of the Dade County Medical Association, a symposium on Chronic Pancreatitis was held. Dr. Chester Cassel spoke on "Diagnosis and Medical Management;" Dr. Richard C. Clay spoke on "Surgical Aspects;" and Dr. David Kirsh spoke on "Radiological Aspects."

DeSoto-Hardee-Highlands-Glades

At the regular meeting of the DeSoto-Hardee-Highlands-Glades County Medical Society, which was held at Aqua Vitae Springs, Zolfo, on June 10, guest speakers were Dr. John S. Helms, Jr., of Tampa who spoke on "Carcinoma of the Breast," and Dr. Karl Zimmerman of Pittsburgh who spoke on "Proctological Problems Which Can Be Handled in the Office."

Duval

At the June meeting of the Duval County Medical Society, it was voted that no meetings be held in July and August.

Escambia

A one-day scientific session of members of the Escambia County Medical Society was held on June 14 at the San Carlos Hotel in Pensacola. Dr.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

FOR SALE: 18 bed approved, two story brick clinic and hospital. Prosperous growing central Florida town. Best location. Beautiful grounds. Fully equipped, X-Ray, operating room and laboratory facilities. Best equipment like new. Inspection invited. Doctor retiring because of health. Ideal for two doctors. Reasonable. Terms. Write 69-66, P. O. Box 1018, Jacksonville, Fla.

James Rives, professor of surgery, Louisiana State University School of Medicine, spoke on "Mediastinal Tumors," and Dr. Tinsley Harrison, professor of medicine, University of Alabama School of Medicine, spoke on "Problems in the Diagnosis of Chest Pain." Dr. Geoffrey Mann, chief medical examiner, Commonwealth of Virginia, was the principal speaker at the luncheon meeting. His subject was "Forensic Medicine."

Local physicians also presented scientific papers during the one-day session. Dr. Bernard M. Barrett spoke on "Head Pain of Allergic Origin;" Dr. Franklin L. DeBusk spoke on "Vitamin Intoxication;" and Dr. Nathan S. Rubin spoke on "What Every Doctor Should Know About Glaucoma," at the morning session. Afternoon speakers included Dr. Francis P. Cassidy who spoke on "Surgical Diseases of the Chest;" Dr. Wendell J. Newcomb who spoke on "Intramedullary Pin Fixation of Femoral Fractures;" and Dr. Frank E. Tugwell who spoke on "Hernia Repair."

Scientific exhibits were under the direction of Dr. Nathan Arenson, Dr. G. Hilbert of the Naval Hospital, and Dr. Rubin.

Franklin-Gulf

Members of the Franklin-Gulf County Medical Society have paid their state dues 100 per cent.

Marion

The Marion County Medical Society sponsored a medical display on the Square in Ocala for a week beginning July 4, according to Dr. Richard C. Cumming, chairman of the committee on public relations. The Society's weekly radio program will be one year old in August. American Medical Association electrical transcriptions from the record library of the Florida Medical Association Bureau of Public Relations are being used for the broadcasts.

Pasco-Hernando-Citrus

At the June meeting of the Pasco-Hernando-Citrus County Medical Society, Dr. John S. Neill, director of the Citrus County Health Department, spoke on "Early Signs of Polio."

Pinellas

The Pinellas County Medical Society has announced that it will not meet in August. The next meeting of the Society will be on September 5.

St. Johns

The medical broadcasts of the St. Johns County Medical Society are running into their fourteenth week. Dr. James J. DeVito, secretary of the Society, is in charge of the programs which are heard over station WFOY, St. Augustine.

Seminole

Members of the Seminole County Medical Society and dentists of Sanford recently enjoyed their annual outing aboard Capt. Gene Roumillat's yacht, Sky Lark.

OBITUARIES

George Howard Carefoot

Dr. George Howard Carefoot of Fort Meade died in the Morrell Memorial Hospital in Lakeland on May 3, 1952 after a long illness. He was 63 years of age.

Born in Toronto, Canada, on Nov. 24, 1888, Dr. Carefoot came to Atlanta, Ga., where he resided with his sister, Dr. Violet Middlebrook, and later attended medical school. He was graduated in 1914 from the Georgia College of Eclectic Medicine and Surgery in that city.

Dr. Carefoot soon was married to Mrs. Cornelia Comer, and they came to Florida to live. After practicing medicine for a time in Worthington Springs, he opened offices in Fort Meade in 1920 and continued to practice there until he became ill several years ago.

This excellent physician served his community long and well professionally and as a citizen. While a member of the City Commission, he served as Mayor-Commissioner of Fort Meade in 1943. He was a Mason and a member of Egypt Temple Shrine.

Dr. Carefoot was a member and a past president of the Polk County Medical Society. He also held membership in the Florida Medical Association and the American Medical Association.

Surviving are the widow, Mrs. Alice Mason Carefoot; one son, George Howard Carefoot, Jr., of Fort Meade; one sister, Mrs. Robert Maxwell of St. Petersburg; two brothers, Dr. E. I. Carefoot of Jacksonville, and Russell Carefoot of St. Petersburg; and two grandchildren, George Howard Carefoot III, and Cornelia Anne Carefoot.

METAMUCIL®

Effective in Distal Colon Stasis*

"A roentgenographic evaluation of the common methods of therapy . . . demonstrated that . . . a mucilloid substance (Metamucil) has been most effective in the most prevalent [type of colonic stasis], distal colon stasis. . . . Enemas gave good results in rectal stasis only. Mineral oil had very little effect. Antispasmodics and sedatives had no efficacy. . . . It was found that the use of habit forming cathartics may be avoided in most instances."*

Comparative Response to Common Methods of Therapy in Distal Colon Stasis*

Number of Hours Residue is Retained	24	48	72	96	120	144	168
Control (No Therapy)				○○○	○○○○○○	○○○○○○	○○○
METAMUCIL	●●●●●●●●●●●●	●●●●	●●●	●	●		
Enemas	●	●●	●	●●●	●●●●●●	●●●	●●●
Antispasmodics				●●●	●●●●●●	●●●●●●	●●●
Mineral Oil		●		●●●	●●●●●●	●●●●●●	●●●

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

METAMUCIL® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis, Scientific Exhibit, National Gastroenterological Association, Chicago, Sept. 17-22, 1951.

RESEARCH IN THE SERVICE OF MEDICINE SEARLE

Rx

...FOR BOTH DOCTOR AND PATIENT

• The name Sealtest is your guarantee of rich, wholesome dairy foods—healthful refreshment at its nourishing best.

Southern Dairies

Sealtest

ICE CREAM

WOMAN'S AUXILIARY
TO THE
FLORIDA MEDICAL ASSOCIATION
OFFICERS

MRS. HERSCHEL G. COLE, President.....*Tampa*
MRS. THOMAS C. KENASTON, President-elect.....*Cocoa*
MRS. RICHARD F. STOVER, 1st Vice Pres.....*Miami*
MRS. NELSON A. MURRAY, 2nd Vice Pres.....*Jacksonville*
MRS. REAVES A. WILSON, 3rd Vice Pres.....*Sarasota*
MRS. TAYLOR W. GRIFFIN, 4th Vice Pres.....*Quincy*
MRS. ALBERT G. LOVE, IV, Recording Sec'y.....*Gainesville*
MRS. HERBERT B. LOTT, Correspd. Sec'y.....*Tampa*
MRS. SAMUEL S. LOMBARDO, Treasurer.....*Jacksonville*

COMMITTEE CHAIRMEN

MRS. CHARLES F. HENLEY, Finance.....*Jacksonville*
MRS. EDWARD F. SHAVER, Today's Health.....*Tampa*
MRS. ALVIN L. MILLS, Legislation.....*St. Petersburg*
MRS. C. RUSSEL MORGAN, JR., Public Relations.....*Miami*
MRS. WILLIAM G. MERIWETHER, Reference.....*Plant City*
MRS. SHERREL D. PATTON, Civil Defense.....*Sarasota*
MRS. CARROLL V. HERRON, Projects.....*Daytona Beach*
MRS. JULIUS ALEXANDER, Program.....*Miami*
MRS. JAMES T. COOK, JR., Bulletin.....*Marianna*
MRS. GEORGE H. PUTNAM, Historian.....*Gainesville*
MRS. ANGUS D. GRACE, Parliamentarian.....*Fort Myers*
MRS. ALFONSO F. MASSARO, Revisions.....*Tampa*
MRS. JOHN E. MAINES, JR., Stu. Loan Fund....*Gainesville*
MRS. ARTHUR R. KNAUF, Mediaix.....*Tampa*
MRS. CHARLES McD. HARRIS, JR., Study Group.....*W. P. Beach*
MRS. C. ROBERT DEARMAS, Auxiliary Writer for State Medical Journal.....*Daytona Beach*
MRS. EDWARD W. CULLIPHER, Stu. Nurse Recruit. *Miami*
MRS. LEFFIE M. CARLTON, JR., Hospitality.....*Tampa*

Lamp Lighters

In the March Bulletin of the Woman's Auxiliary to the American Medical Association, Dr. Ernest B. Howard, Assistant Secretary, A. M. A., says something in his "Thoughts for the Future" which significantly emphasizes a principle held by the Florida Medical Association.

"I might add another word of advice. It is this: Limit your Auxiliary activities to projects in the field of health. Many worthy causes will seek the aid of your group. Improvements can be made in almost every aspect of community life. Your organization, however, is a medical auxiliary and it is in the field of health and medical care that you and your physician husbands will be held accountable. There is much to be done in this field. Better, then, to mend our own fences, and to build strong new ones, than to assume other problems. This must not be interpreted to mean that, as individuals, you should not be active in other organizations. On the contrary, it is vitally important that physicians and their wives be working citizens of their communities. The above advice applies only to projects adopted officially by your Auxiliary."

One of the best ways to uphold this principle as well as to contribute a valuable service to the community is to develop interest in nurse recruitment. This field needs ploughing. Many auxiliaries throughout the nation are actively working

at providing scholarships for girls who are interested in this profession but find it economically untenable for enrolment.

In Florida we have a Student Loan Fund which matches the amount provided by the local Auxiliary to help a girl along the road. This is a valuable project and one which is being adopted by most of the Auxiliaries. However, in communities where the local group has a minimum fund from which to draw, we must not lose sight of the vast good which can be accomplished in this field through education.

We must not assume that only girls without sufficient funds to make this profession her life's work are interested in nursing, thereby scrapping the project if money is not available. More girls than we are aware of would pursue this line of work if they knew about it and were provided with information concerning the requirements as well as the nature of the life they would lead in a nurses' training school.

We are in a position to provide this information. Our awareness of the need the public and doctors have for good nurses should make us carry the literature, films and facts to the generation of girls who are growing up in our schools today. We must carry more to them than statistics and material symbols. No matter how we shine the outside of the lamp, unless we interpret to the young mind, the essence of what it takes to make the lamp burn brightly and create the idealism necessary to make them yearn to carry it through life we will fail. Because of a materialistic trend of figuring which has invaded our social pattern, all pursuits have been reduced to a common denominator of "what's in it for me?" And the yardstick of success has become a measure of security rather than one of challenge.

We who are adult are responsible for the "money changers in the temple." Only we can replace gain with compassion. In order to do this we must refuel the lamps and carry the light of self sacrifice and service to our fellow man into the market place. We must sell the youth of America on the only fuel which will burn brightly through a crisis. The oil in the Nightingale lamp was balm to the wretched, the injured and the dying. It gives warmth and guidance and lubricates the ideals so necessary to the soul of man.

Mrs. C. Robert DeArmas

Advertisement

From where I sit *by* Joe Marsh

How Nervy Can a "Tenant" Get?

"Harry the Hermit" dropped in to see Judge Cunningham the other day and started complaining about that old dilapidated house he lives in over near Greenwood Lake.

"Who's my landlord?" Harry wanted to know. "Whoever you pay rent to," says the Judge. "Don't pay any rent," says Harry. "Moved into that house twelve years ago and nobody ever came to collect."

"Well," says the Judge, looking mystified, "what do *you* have to complain about?" "Plenty," replies Harry. "Rain's pouring in my living room and if someone doesn't fix that roof, I'm moving out!"

Now Harry was only having a little joke, but from where I sit I've seen people act about as nervy as this sometimes—seriously. Like those who enjoy all the rights Americans have worked for, and yet would take away some of those freedoms from others—for example, our right to enjoy a friendly glass of beer or our right to practice our profession without interference.

Joe Marsh

Copyright, 1952, United States Brewers Foundation

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting September 3, September 22, October 6. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting September 8, October 20. Surgical Anatomy & Clinical Surgery, Two Weeks, starting September 22, November 3. Surgery of Colon & Rectum, One Week, starting September 15. Gallbladder Surgery, Ten Hours, starting October 20. Basic Principles in General Surgery, Two Weeks, starting September 8. General Surgery, One Week, starting October 6. General Surgery, Two Weeks, starting October 6. Breast & Thyroid Surgery, One Week, starting October 6. Esophageal Surgery, One Week, starting October 13. Thoracic Surgery, One Week, starting October 20. Fractures & Traumatic Surgery, Two Weeks, starting October 6.

GYNECOLOGY—Intensive Course, Two Weeks, starting September 8, October 20. Vaginal Approach to Pelvic Surgery, One Week, starting September 22, November 3.

OBSTETRICS—Intensive Course, Two Weeks, starting September 29, November 3.

MEDICINE—Electrocardiography & Heart Disease, Two Weeks, starting September 29. Intensive General Course, Two Weeks, starting October 13. Gastroscopy & Gastroenterology, Two Weeks, starting September 15, November 3.

UROLOGY—Intensive Course, Two Weeks, starting September 8. Cystoscopy, Ten Days, starting every two weeks.

DERMATOLOGY—Intensive Course, Two Weeks, starting October 13.

Teaching Faculty:

Attending Staff of Cook County Hospital

Address: Registrar, 707 South Wood Street

Chicago 12, Illinois

MAC'S WALKERS

Made of light weight steel tubing (5lb.) Welded joints for strength and rigidity. Can't slip or turn. Safer than crutches. Stock sizes 32, 33, 34, 35, 36 inches. Give height of person when ordering. Children's and special sizes made to order. Price $11.00 delivered in Florida.

Made by

H. W. McCORD

2018 W. Fairbanks Avenue

WINTER PARK, FLORIDA

BOOKS RECEIVED

Office Endocrinology. By Robert B. Greenblatt, M.D. Pp. 561. Price, $10.50. Springfield, Ill., Charles C. Thomas, Publisher, 1952.

Published in April, this fourth edition of Office Endocrinology was prepared with the general practitioner in mind and not the man primarily working in the field of endocrinology. It has been, to a large extent, rewritten. Several chapters have been deleted, many have been altered considerably and some 20 new chapters have been added.

The author has approached the subject matter from a clinical rather than an experimental point of view; he has emphasized the characterization and treatment of clinical endocrinopathies. He states that he has written only of what he knows — of those aspects of endocrinology and related fields with which he has had personal experience. The various subjects discussed, the endocrine and pharmacologic preparations recommended, the diagnostic tests outlined and the office procedures described have all been tried, used and evaluated in his office work, clinic and laboratory.

Dr. Greenblatt is Professor of Endocrinology at the Medical College of Georgia and Chief of Endocrinology of the University Hospital. In the foreword, Dr. G. Lombard Kelly, President of the Medical College of Georgia, observes that in this biochemical epoch clinical investigators, such as the author of this book, fortunately have kept pace with the biochemists and physiologists with the result that the average clinician may now avail himself of the wonderful new discoveries as they apply to the patients in their keeping. This book meets the needs of the practicing physician.

The Origin of Life and the Evolution of Living Things, An Environmental Theory. By Olan R. Hyndman, B.S., M.D., F.A.C.S. Pp. 648. Price, $8.75. New York, Philosophical Library, 1952.

One trained in the field of medicine here attempts to explain the origin and evolution of living things on a physicochemical basis and as expressions of the operation of natural law. Consideration is given to origin with the view that this is mandatory to an understanding of the basic principles of evolution. Certain key principles that are believed to govern organic evolution are suggested for the first time. Application of one of these principles provides a formal explanation for the male and female elements, for fertilization, and for bizarre and heretofore unexplained events that accompany maturation of sperm and eggs.

The theory is in opposition to the current teaching that fortuitous mutation is the fundamental mechanism of evolution. It holds that changes in the germ plasm are governed by environmental influences on the soma and hence opposes Weismann's view and certain of Darwin's views. It endorses multiple and continuous origins and accounts for the wide differences in species on the basis of differences in environment of origin and subsequent evolution. The range of species from virus to the human resolves into four distinct orders of differentiation, each order being represented by its indivisible and characterizing unit.

It is suggested that this theory may throw new light on the nature of biologic disorder, human behavior, and the cause and development of cultures.

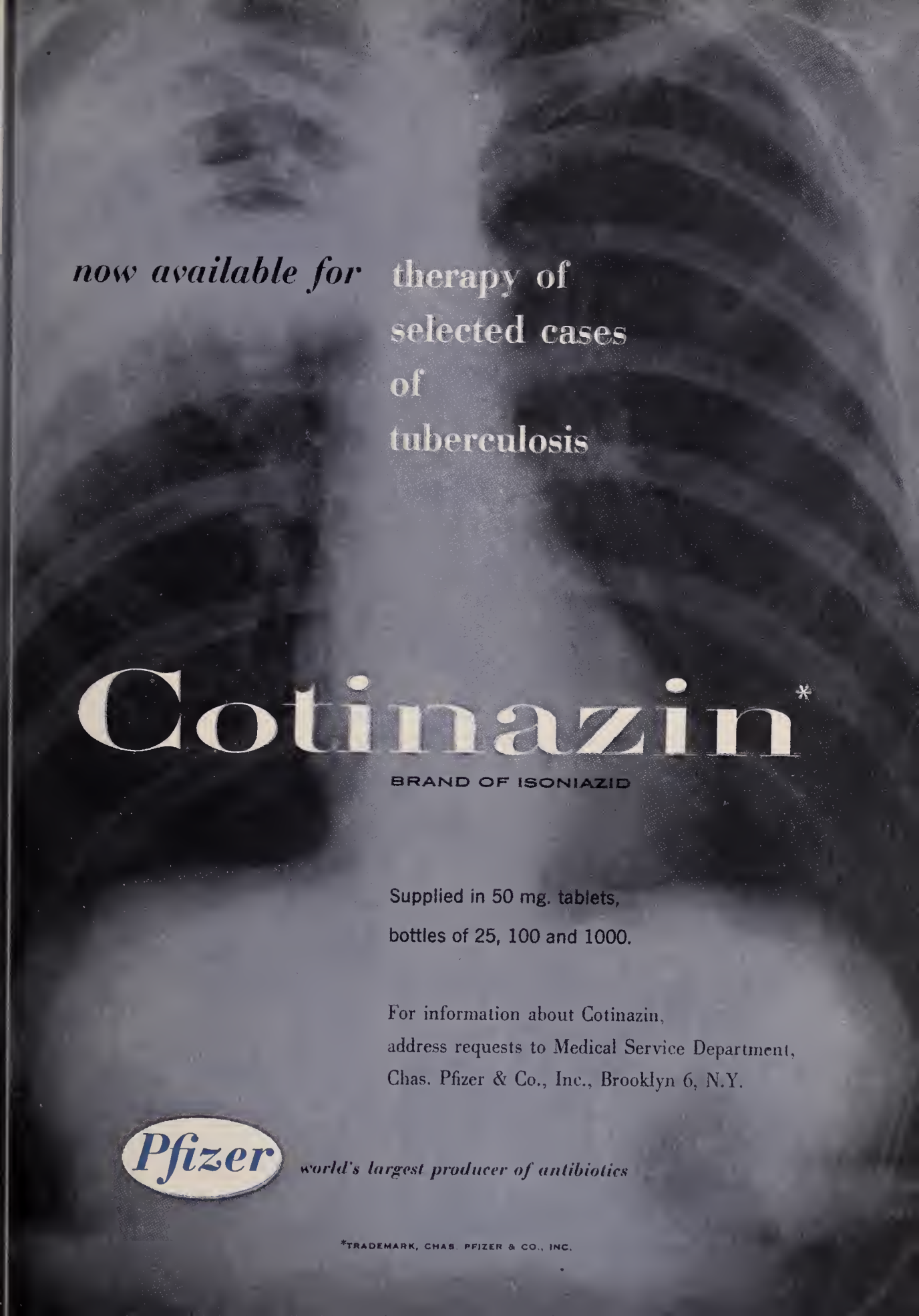
Ambulance Service

FERGUSON FUNERAL HOME

H. E. Ferguson, Licensed Director

1201 South Olive

WEST PALM BEACH, FLA.


now available for
therapy of
selected cases
of
tuberculosis
Cotinazin*
BRAND OF ISONIAZID
Supplied in 50 mg. tablets,
bottles of 25, 100 and 1000.
For information about Cotinazin,
address requests to Medical Service Department,
Chas. Pfizer & Co., Inc., Brooklyn 6, N.Y.
Pfizer
world's largest producer of antibiotics
*TRADEMARK, CHAS. PFIZER & CO., INC.

Specialized
LABORATORY SERVICES

Thyroid Activity
determined by
SERUM PROTEIN-BOUND IODINE
a reliable index to presence and course of

Hypo ond Hyper Thyroidism
now available routinely.
(12 cc. clotted blood required)

FLAME PHOTOMETRY
A safeguard against

ELECTROLYTE IMBALANCE
by most reliable, rapid instrument.

SODIUM, POTASSIUM AND CALCIUM TESTS
(1.0 cc. serum each test — 24 hrs. service)

URINE 17 KETOSTEROIDS TESTS
Available soon — Micro method 25 cc. required

Containers, instructions and rates on
request for physicians and hospitals.
Airmail — Special Delivery Suggested

Reseorch Consulting

SHAW LABORATORIES
1923 14th Ave., So.
Birmingham, Alabama

Office Phone 4-4733 Night Phone 54-5960

THE EARLE JOHNSON SANATORIUM

For the care of nervous, mental, senile, alcoholic, and addicted cases. **Moderate rates.**

Operated by C. Earle Johnson, Jr., M.D., Psychiatrist-in-Chief, F.A.P.A., F.A.C.P. Diplomate of the American Board of Psychiatry and Neurology.

The most modern and effective psychiatric methods are employed.

Telephone: 3-3369 or 3-3360
Write: Drawer 106
Meridian, Mississippi

AVOID "OVERTREATMENT DERMATITIS"
"Overtreatment dermatitis is today a prevalent and often disabling cutaneous disturbance."*
* Lane, C. G., "Therapeutic Dermatitis", New Eng J Med., 246:77 81, 1952
AVEENO...the mild, soothing concentrote from ootmeol provides colloidol protection and emollient relief for irritoted ond itching skin oreos . . . in colloid boths ond in locol opplications.
Send for samples E. FOUGERA & CO., INC. • Distributors • 75 Varick St., New York 13, N. Y.

MIAMI MEDICAL CENTER

P. L. DODGE, M.D.
Medical Director and President

1861 N. W. South River Drive
Phones 2-0243 — 9-1448

A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures — Psychotherapy, Insulin, Electroshock, Hydrotherapy, Diathermy and Physiotherapy when indicated. Adequate facilities for recreation and out-door activities. Cruising and fishing trips on hospital yacht.

Information on request
Member American Hospital Association

CAMEL
CAMEL
CAMEL
CAMEL
CAMEL
TURKISH & DOMESTIC BLEND CIGARETTES
CHOICE QUALITY
More people get more pleasure from Camels than from any other cigarette!

Janet's Nursery for Babies
P. O. Box 191
OSPREY, FLORIDA
Phone RIngling 4-1647

A Nursery for Handicapped Babies

For Information write
H. KEITH JACOBUS
P. O. Box 191
Osprey, Florida

S. A. Kyle *Funeral Director*

MEMBER National Selected Morticians BY INVITATION

17 WEST UNION STREET
JACKSONVILLE 2, FLORIDA
Phones 5-3766 5-3767

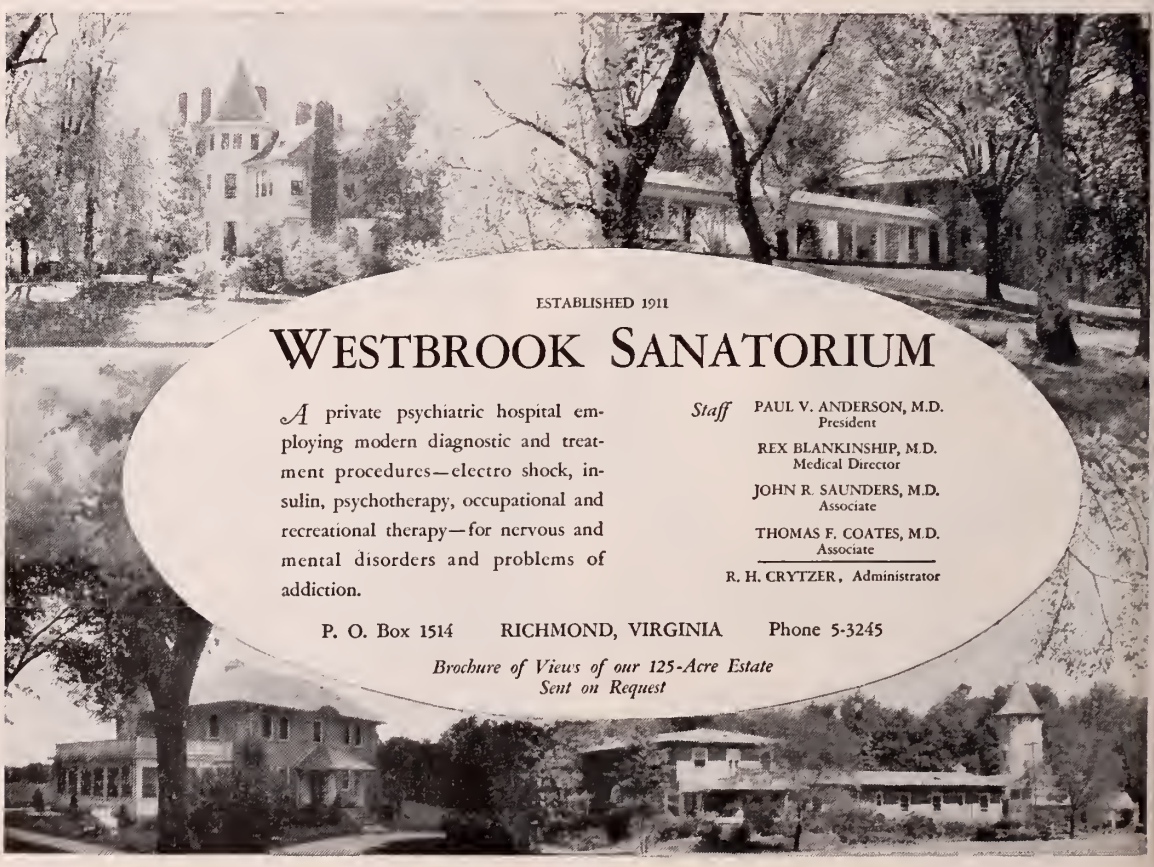
• In MIAMI
SANITARIUM

Medical Hospital American Plan Hotel for Patients and their families. REST, CONVALESCENCE, ACUTE and CHRONIC MEDICAL CASES. Elderly People and Invalids. *FREE Booklet!*

Acres Tropical Grounds, Delicious Meals, Res. Physician, Grad. Nurses, Dietitian.

SUN-RAY PARK HEALTH RESORT

Mild Mental Cases, Drug and Alcoholics in Separate Building



ESTABLISHED 1911

WESTBROOK SANATORIUM

A private psychiatric hospital employing modern diagnostic and treatment procedures—electro shock, insulin, psychotherapy, occupational and recreational therapy—for nervous and mental disorders and problems of addiction.

Staff PAUL V. ANDERSON, M.D.
President
REX BLANKINSHIP, M.D.
Medical Director
JOHN R. SAUNDERS, M.D.
Associate
THOMAS F. COATES, M.D.
Associate
R. H. CRYTZER, Administrator

P. O. Box 1514 RICHMOND, VIRGINIA Phone 5-3245

Brochure of Views of our 125-Acre Estate Sent on Request

The Right to *Choose* . . . .

CORNERSTONE OF AMERICAN LIBERTY

Hospital Expense Plans

Medical-Surgical Expense Plans

Paycheck Protection Plans

Life Insurance Plan

AS long as Americans keep the right to choose — their church, their political party, their doctor and their hospital — freedom must prevail.

We are proud that hundreds of thousands of Americans have freely chosen the protection afforded them by PENNSYLVANIA LIFE'S liberal, low-cost health insurance plan.

Pennsylvania Life
HEALTH & ACCIDENT **Insurance Company**

FOUNDED 1890

HOME OFFICE: PHILADELPHIA 5, PA.

19 District Offices in Florida

Miami	Executive Office 3028 Biscayne Blvd.	Fort Lauderdale	521½ South Andrews Avenue
	Downtown 1210 Pacific Building	Jacksonville	303 Clark Building
	Southwest 1260 S. W. 22nd Street	Tampa	228 Cass Street Arcade Building
	Little River 8340 N.E. Second Ave., Suite 245	Sarasota	237 Main Street, Room 15
	Coral Gables 3028 Biscayne Blvd.	Fort Pierce	Florida Bank Building, Room 34
	Miami Beach 206 Harvey Building	Daytona Beach	116½ Orange Avenue
St. Petersburg	509 White Building	Tallahassee	429 Centennial Building
Lakeland	206 Marble Arcade	Panama City	142 Harrison Avenue
West Palm Beach	305 Citizens Building	Pensacola	501 Theisen Building
Orlando	209 Slayton Building		

Allen's Invalid Home

MILLEDGEVILLE, GA.

Established 1890
For the treatment of
NERVOUS AND MENTAL DISEASES

Grounds 600 Acres
Buildings Brick Fireproof
Comfortable Convenient
Site High and Healthful

E. W. ALLEN, M.D., *Department for Men*
H. D. ALLEN, M.D., *Department for Women*
Terms Reasonable

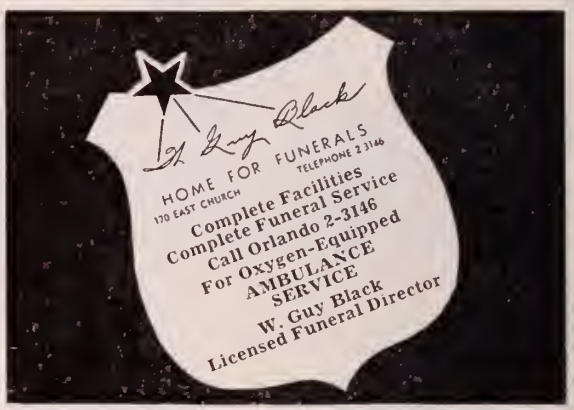
BISCAYNE HOSPITAL

6339 Biscayne Blvd.
MIAMI 38, FLORIDA

Members of the Dade County Medical Association are acquainted with the high type of service rendered.

David Collins, Superintendent

Registered, American Medical Association
Phone 7-4544



CONVENTION PRESS

218 WEST CHURCH STREET
JACKSONVILLE
FLORIDA

Commercial and
Publication
Printing

BRAWNER'S SANITARIUM

Established 1910

SMYRNA, GEORGIA
(Suburb of Atlanta)

For Nervous and Mental Disorders
Drug and Alcohol Addiction
Electro-Shock in selected cases

JAMES N. BRAWNER, M.D., Medical Director
ALBERT F. BRAWNER, M.D., Department for Men
JAMES N. BRAWNER, JR., M.D., Department for Women

One of America's Fine Institutions . . . .

Newdigate M. Owensby, M.D.
Psychiatrist-in-Chief
Specialist Certified by the American Board of Psychiatry and Neurology

Willis T. McCurdy, M.D.
Attending Physician

J. Rufus Evans, M.D.
Attending Physician

Elizabeth Hancock
Psycho-Therapist

Atlanta Office,
384 Peachtree Street

Dedicated to the Scientific Treatment of Nervous and Mental Disorders . . .
. . . In a setting of Inviting Friendliness and Simple Grace . . . Elevation 1200 Feet

BROOK HAVEN MANOR SANITARIUM

STONE MOUNTAIN, GA.

HILL CREST SANITARIUM

FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

Thoroughly modern in architecture and construction. Eight departments — affording proper classification of patients. All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

James A. Becton, M.D., Physician-in-charge — James Keene Ward, M.D., Associate Physician

P. O. Box 2896, Woodlawn Station, Birmingham, Alabama — **Phones 9-1151 and 9-1152**

TUCKER HOSPITAL, INC.

212 West Franklin Street

RICHMOND, VIRGINIA

A private hospital accepting for diagnosis and treatment organic neurological conditions, selected psychiatric and alcoholic cases, metabolic disturbances of an endocrine nature, individuals who are having difficulty with their personality adjustments, and children with behavior problems. Patients with general medical disorders admitted for treatment under our staff of visiting physicians.

Under the Professional Charge of

DR. HOWARD R. MASTERS,
DR. JAMES ASA SHIELD AND ASSOCIATES

HIGHLAND HOSPITAL, INC.

FOUNDED IN 1904

Asheville, North Carolina

AFFILIATED WITH DUKE UNIVERSITY

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a sixty-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D.,
Diplomate in Psychiatry
Medical Director

ROBT. L. CRAIG, M.D.,
Diplomate in Neurology and Psychiatry
Associate Director

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Medical Association	Robert B. McIver, Jacksonville	Samuel M. Day, Jacksonville	Hollywood, Apr. 26-29, '53
Medical Districts	Eugene G. Peek, Jr., Ocala	Council Chairman	
rthwest	Francis M. Watson, Marianna	Benjamin A. Wilkinson, Tallahassee	Panama City, Oct. 27, '52
rtheast	William C. Thomas, Jr., Gainesville	Eugene L. Jewett, Orlando	Daytona Beach, Oct. 31, '52
uthwest	Emmett E. Martin, Haines City	Hugh G. Reaves, Sarasota	St. Petersburg, Oct. 29, '52
utheast	Erasmus B. Hardee, Vero Beach	Donald W. Smith, Miami	Ft. Pierce, Oct. 30, '52
Specialty Societies			
y of General Practice	Edward F. Shaver, Tampa	Frank T. Linz, Tampa	Hollywood, Apr. 26, '53
Society	Nelson Zivitz, Miami Beach	Solomon D. Klotz, Orlando	" "
siologists, Soc. of	John T. Stage, Jacksonville	Breckenridge W. Wing, Orlando	" "
, Am. Coll. Chest Phys	Alexander Libow, Miami Beach	DeWitt C. Daughtry, Miami	" "
nd Syph., Soc. of	Lewis Capland, Miami Beach	Morris Waisman, Tampa	" "
Officers' Society	George W. Edwards, II, Orlando	Lorenzo L. Parks, Jacksonville	" "
ial & Railway Surgeons	John H. Mitchell, Jacksonville	William H. Chapman, Jacksonville	" "
gy & Psychiatry	W. Tracy Haverfield, Miami	Roger E. Phillips, Orlando	" "
l Gynec. Society	Dorothy D. Brame, Orlando	J. Champneys Taylor, Jacksonville	" "
l & Otol., Soc. of	Joseph W. Taylor, Sr., Tampa	Carl S. McLemore, Orlando	" "
dic Society	Arthur H. Weiland, Coral Gables	Edward W. Cullipher, Miami	" "
gists, Society of	Robert J. Poppiti, Miami Beach	Alfred E. Cronkite, Fort Lauderdale	" "
c Society	Egbert V. Anderson, Pensacola	J. K. David, Jr., Jacksonville	W. Palm Beach, Nov. 8-9, '52
gic Society	Alex. E. Rosenberg, Miami Bch.	George Williams, Jr., Miami	Hollywood, Apr. 26, '53
gical Society	Thomas H. Lipscomb, Jacksonville	A. Judson Graves, Jacksonville	" "
al Society	George H. Putnam, Gainesville	David W. Goddard, Daytona Beach	" "
—			
Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Oct. 25, '52
l Banks, Association	Donald W. Smith, Miami	Mr. J. M. Potts, Miami	
Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Daytona Beach, Nov. 16, '52
Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Mother Loretto Mary, Tampa	Hollywood, Apr. 26, '53
r Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	
l Society, State	W. G. McLeod, D.D.S., Pensacola	Coleman Brown, D.D.S., Tampa	St. Petersburg, Apr. 20-23, '53
Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
tal Association	Mother Loretto Mary, Tampa	Tracy B. Hare, Miami	Daytona Beach, Nov. '52
al Examining Board	Ralph B. Spires, DeFuniak Springs	Homer L. Pearson, Jr., Miami	Jacksonville, Nov. 23-25, '52
al Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
s Association, State	Miss Undine Sams, Miami	Bertha King, Tampa	St. Petersburg, Nov. 14-16, '52
naceutical Association, State	Mr. Clyde Morris, Daytona Beach	Mr. R. Q. Richards, Ft. Myers	St. Petersburg, May, '53
c Health Association	Mrs. May Pynchon, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Jacksonville, Oct., '52
culosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Elsa B. Conant, Pt. St. Joe	
an's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	Hollywood, Apr. 26-28, '53
n Medical Association	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	New York, June 1-5, '53
A. Clinical Session	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	Denver, Dec. 2-5, '52
n Medical Association	R. J. Wilkinson, Huntington, W. Va	Mr. C. P. Loranz, Birmingham	Miami, Nov. 10-13, '52
a Medical Association	B. W. McNease, Fayette	Douglas L. Cannon, Montgomery	Birmingham, Apr. 16-18, '53
, Medical Assn. of	C. F. Holton, Savannah	Mr. Sid Wrightsman, Atlanta	Savannah, May 10-13, '53
ospital Conference	Mr. Norman Losh, Orlando	Mr. D. O. McClusky, Tuscal'sa, Ala.	New Orleans, April 8-10, '53
stern Allergy Assn.	Clarence Thomas, Nashville, Tenn.	Kath. B. MacInnis, Columbia, S. C.	
stern, Am. Urological Assn.	William Miner, Covington, Ky.	Sidney Smith, Raleigh, N. C.	Havana, Cuba, Mar. 26-29, '53
stern Surgical Congress	H. L. Claud, Washington, D. C.	B. T. Beasley, Atlanta	Louisville, Mar. 9-12, '53
ast Clinical Society	Alvin L. Stebbins, Pensacola	Dale E. York, Pensacola	Pensacola, Oct. 16-17, '52

MIAMI RETREAT SANATORIUM

FOUNDED 1927

For Nervous and Mental Disorders, Alcohol and Drug Addiction

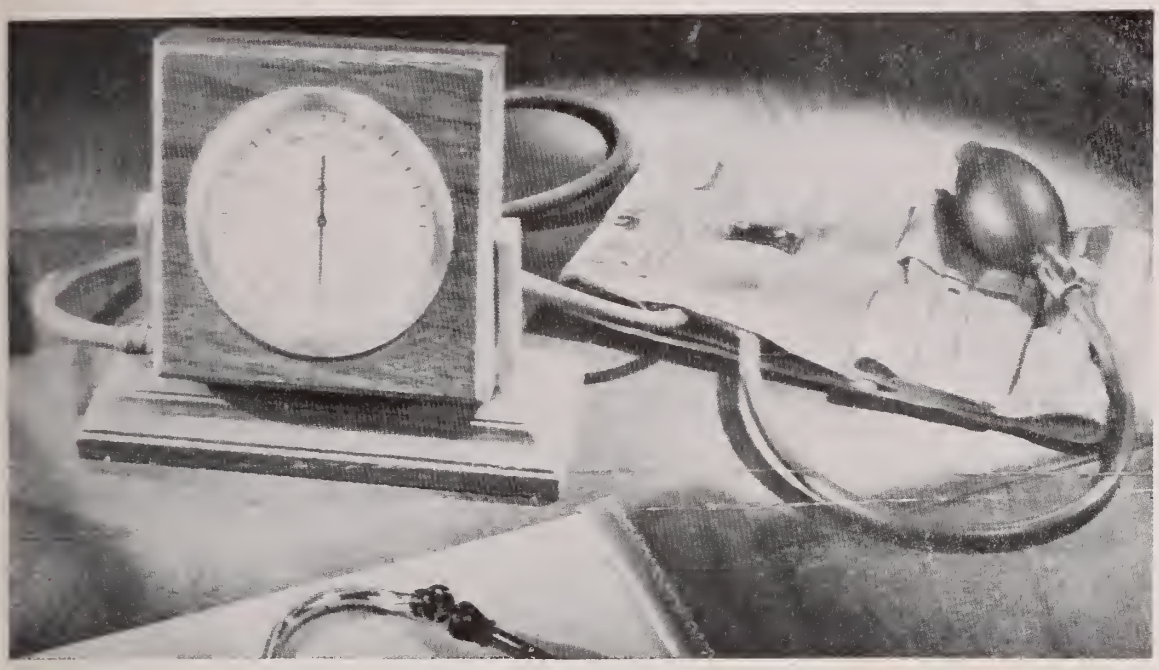
STAFF OF EIGHT NEUROPSYCHIATRISTS
New X-Ray Diagnostic Treatment Facilities
Comfortable AIR-CONDITIONED rooms, suites

79TH STREET AT MIAMI AVENUE
MIAMI 38, FLORIDA

Phone 7-1824

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
					Total	Paid	
A	Bay	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	William F. Humphreys, Jr., M.D. 112 E. 3rd Court Panama City		24	100%	
	Escambia *Santa Rosa*	Chas. J. Heinberg, M.D. 109 N. Baylen St. Pensacola	Raymond B. Squires, M.D. 386 Brent Bldg. Pensacola	2nd Tuesday 8:00 P.M.	75	70	
	Franklin-Gulf	John W. Hendrix, M.D. Port St. Joe	William P. Blackmon, M.D. Apalachicola	Last Wednesday	8	100%	A-1-54 Francis M. Watson, M.D Marianna
	Jackson-Calhoun	Albert E. McQuagge, M.D. 207 N. Green St. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	15	
	Walton-Okaloosa	William D. Cawthon, M.D. DeFuniak Springs	Edgar H. Myers, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	15	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Baylye W. Dalton, M.D. Chipley		5	100%	
	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	100%	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	Ernest W. Ekermeyer, M.D. 516 N. Adams St. Tallahassee	George H. Massey, M.D. 204 N. Madison St. Quincy	Quarterly 7:30 P.M.	58	53	
	Suwannee	Edward G. Haskell, Jr., M.D. Branford	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak	1st Saturday 9:30 A.M.	9	100%	A-2-53 Benjamin A Wilkinson, M. Tallahassee
	Madison	A. Franklin Harrison, M.D. Madison	Eugene D. Thorpe, M.D. Madison		3	100%	
	Taylor *Dixie, Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	1	233
B	Alachua *Bradford, Gilchrist, Union*	Henry J. Babers, Jr., M.D. Box 709 Gainesville	Raymond S. Camp, M.D. 907 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	49	48	
	Duval *Clay*	Ferdinand Richards, M.D. 508 Greenleaf Bldg. Jacksonville	Joseph A. J. Farrington, M.D. 415 Greenleaf Bldg. Jacksonville	1st Tuesday 8:15 P.M.	254	228	
	Marion *Levy*	Carl S. Lytle, M.D. 1206 E. Ocklawaha Ave. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	30	26	B-3-54 William C. Thomas, Jr., M Gainesville
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	10	9	
	Putnam	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	Bennie J. Massey, M.D. Box 105 Palatka	2nd Tuesday 6:00 P.M.	11	10	
	St. Johns	Charles C. Grace, M.D. 145 King St. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
	Brevard	James A. Sewell, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	23	21	
	Lake *Sumter*	Robert H. Montgomery, M.D. Mount Dora	J. Basil Hall, M.D. Mount Dora	1st Wednesday 7:30 P.M.	26	25	B-4-53 Eugene L. Jewett Orlando
	Orange *Osceola*	Carl S. McLemore, M.D. 1217 Kuhl Ave. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	153	141	
	Seminole	Julian N. Tolar, M.D. First Street Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	16	100%	
	Volusia *Flagler*	J. Richard West, M.D. 224 S. Palmetto Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	80	79	667
C	Hillsborough	Sherman B. Forbes, M.D. 409 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	173	153	
	Manatee	John E. Granade, M.D. 114 Walcaid Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	19	16	
	Pasco-Hernando- Citrus	William H. Walters, Jr., M.D. Lacoochee	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	17	16	C-5-53 Hugh G. Reaves Sarasota
	Pinellas	John P. Rowell, M.D. 2500 Driftwood Rd., S. E. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Monday 6:30 P.M.	191	186	
	Sarasota	Henry G. Morton, M.D. 555 Golf St. Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	2nd Tuesday 8:30 P.M.	44	100%	
	DeSoto-Hardee- Highlands- Glades	Harold S. Agnew, M.D. 705 E. Oak St. Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	26	23	
	Lee-Charlotte- Collier-Hendry	John S. Stewart, M.D. Lee Memorial Hosp. Fort Myers	Harvie J. Stipe, M.D. 210 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	24	23	C-6-54 Emmett I Martin, M. Haines Ci
	Polk	Ivan W. Gessler, M.D. 402 Professional Bldg. Winter Haven	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	90	82	584
D	Indian River	P. T. McClellan, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	6	
	Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Drive West Palm Beach	David A. Newman, M.D. 511 Citizens Bldg. West Palm Beach	3rd Monday 8:00 P.M.	117	115	D-7-54 Erasmus Hardee, M Vero Bea
	St. Lucie- Okeechobee- Martin	Richard F. Sinnott, M.D. 209 Koblegard Bldg. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	15	12	
	Broward	Lloyd U. Lumpkin, M.D. 918 E. Las Olas Blvd. Ft. Lauderdale	William K. Peck, M.D. 915 N. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	82	72	
	Dade	Ralph S. Sappenfield, M.D. 630 duPont Bldg. Miami	Nelson Zivitz, M.D. 311 Lincoln Rd. Miami Beach	1st Tuesday 8:30 P.M.	602	524	D-8-53 Donald W. Smi Miami
	Monroe	James B. Parramore, M.D. Box 326 Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	13	12	836

It's New . . .



TYCOS DESK MODEL SPHYGMOMANOMETER

Easy to see it work. A Beautiful Desk Piece. Accurate if the hand is in circle.

Available from us. . .

With Hook Cuff . . . $49.50

With Bandage Cuff $46.50

MEMBER

AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A. Dealers and Service

Anderson Surgical Supply Co.

Established 1916

Telephone 5-8391
40-42 W. DUVAL STREET
P. O. Box 1799
JACKSONVILLE 1, FLORIDA

Telephone 2-8504
1101-1105 TAMPA STREET
P. O. Box 1228
TAMPA 1, FLORIDA

Telephone 7-4589
21 3rd STREET N.
ST. PETERSBURG, FLORIDA

NEW YORK ACADEMY OF MEDICINE
2 E 103RD ST
NEW YORK N Y 29
2
J C-E

Olac

Mead's powdered formula designed for both full term and premature infants

gives a strong start for a healthy childhood

Excellent tissue turgor and muscle development in babies fed Olac® are clearly shown by steadily increasing clinical observatians. These babies tend ta gain weight without becaming fat, are sturdy, and resist infections well. They are generally vigorous, with happy dispasitions. They get a *strong start* far a healthy childhaod.

Designed for optimum nutrition af bath full term and premature infants, Olac supplies milk protein in exceptianally generaus amaunts, ta pramate *sturdy growth*. Its fat is an easily digested, highly refined vegetable ail. Dextri-Maltase® supplements the lactase of the milk, ta meet energy needs and spare pratein for its essential tissue-building functians.

Convenient and simple to use, Olac feedings are prepared merely by adding water. A canvenient special measure is enclosed in each can. One packed level measure af Olac to 2 aunces of water gives a farmula supplying 20 calaries per fluid aunce. Olac is valuable nat anly for bottle-fed infants but far supplementary and camplementary feedings of breast-fed infants.

MEAD'S

Local Representative: Roger J. McElroy, 3181 McDonald Street, Coconut Grove 33, Florida, 4-4124.

MEAD JOHNSON & COMPANY
Evansville 21, Indiana, U. S. A.

The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXIX SEPTEMBER, 1952 No. 3

SEP -9 1952
LIBRARY

IN THIS ISSUE

Surgery of Ruptured Intervertebral Disk
William Jason Mixter

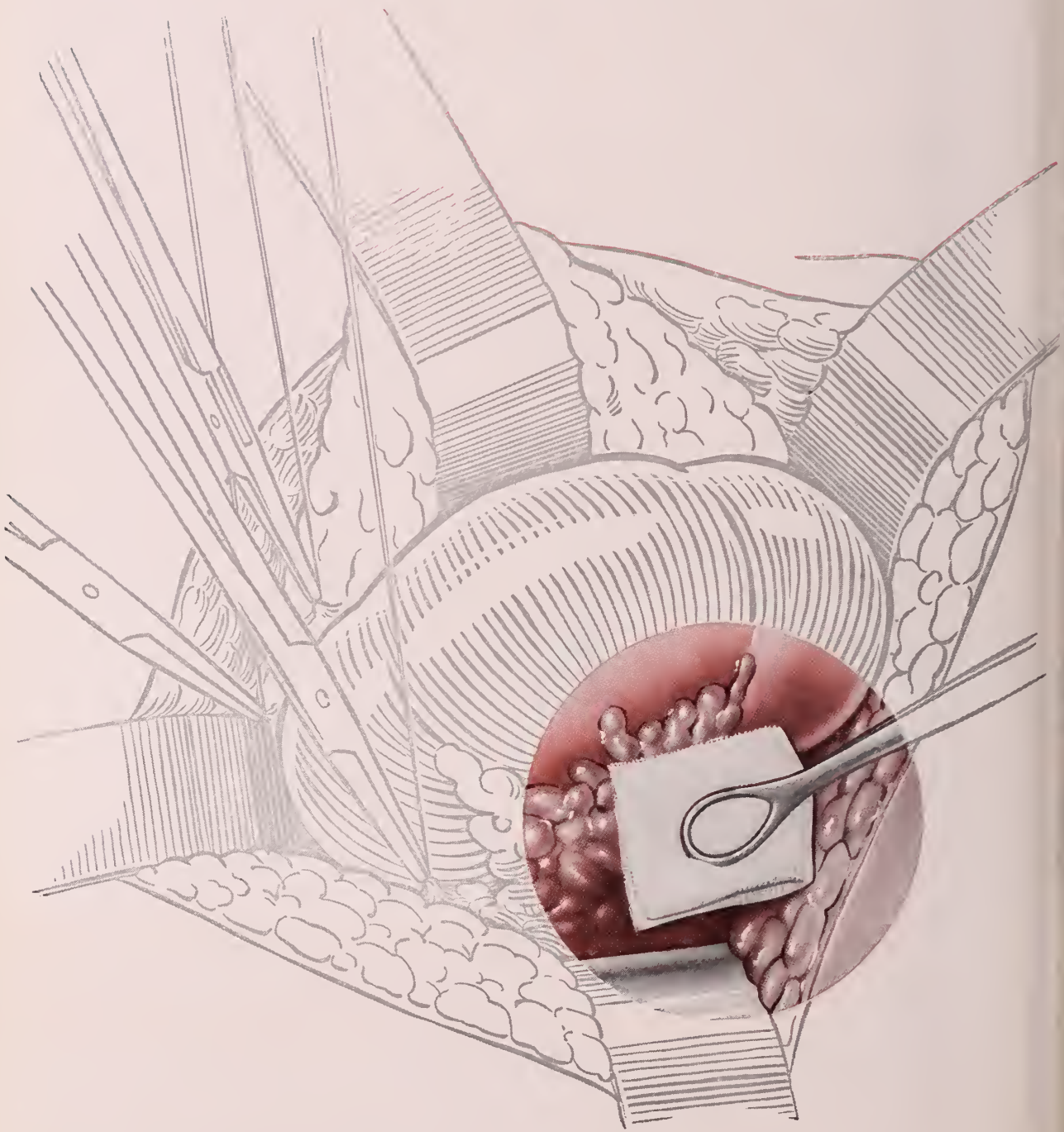
Use of Long-Acting Corticotrophic Preparation
Carlos P. Lamar

Blood Transfusion Problems
John T. Stage, J. Champneys Taylor and James R. Barr

Federal Thought Control
Virgil M. Newton, Jr.

OFFICIAL PUBLICATION OF THE
FLORIDA MEDICAL ASSOCIATION

clamp and ligate where you ca



but where you can't...

OXYCEL®

oxidized cellulose

Where clamp and ligature cannot control capillary bleeding, OXYCEL (oxidized cellulose, Parke-Davis) provides prompt hemostasis. Operative procedure is shortened and postoperative hemorrhage often eliminated by use of this absorbable hemostatic. OXYCEL is easy to use — it is applied directly from the container, and conforms readily to all wound surfaces There's a form of OXYCEL for every surgical use.

CEL PADS

zed, gauze-type,
x 3 inch eight-ply pads,
inch x 12 inch
ply pads.

CEL PLEDGETS

zed, cotton-type, 2¼ inch
h x 1 inch portions.

CEL STRIPS

zed, four-ply, gauze-type
5 inch x ½ inch; four-
inch x 2 inch; four-ply
h x ½ inch; and
ly 3 yard x 2 inch,
d in accordion fashion.

CEL FOLEY CONES

zed, four-ply, gauze-
liscs, 5 inch and 7 inch
ters, conveniently folded
ially fluted form.

ied in individual
containers.

MEDICAMENTA VERA

Parke, Davis & Company

DETROIT, MICHIGAN

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

Volume XXXIX SEPTEMBER, 1952 No. 3

CONTENTS

SCIENTIFIC ARTICLES

Pitfalls in the Surgery of the Ruptured Intervertebral Disk, William Jason Mixter, M.D. 159
Experiences with the Therapeutic Use of a Long-Acting Corticotrophic Preparation, Carlos P. Lamar, M.D. 167
Blood Transfusion Problems, John T. Stage, M.D., J. Champneys Taylor, M.D., and James R. Barr, M.D. 173
Federal Thought Control a Challenge to American Liberties and Freedom, Virgil M. Newton, Jr. 179

ABSTRACTS OF MEDICAL ARTICLES

Drs. Robert M. Alexander, S. B. Forbes, and Thomas M. Edwards 185

EDITORIALS AND COMMENTARIES

The New World 189
Changing Income Distribution 196
Static Electricity Dangers 197
A. M. A. President September Visitor to Florida 198
Report of Delegates to A. M. A., Chicago, June 9-13, 1952 199
Observations Relating to the Use of Camma Globulin in Prevention of Paralytic Poliomyelitis 204
Graduate Medical Education 204

GENERAL FEATURES

Officers and Committees 186
From Our President 188
Florida Blue Shield 204
Medical Officers Returned 205
New Members 205
Births, Marriages and Deaths 205
State News Items 206
Wanted — For Sale 208
Component Society Notes 208
Obituaries 210
Woman's Auxiliary 212
Schedule of Meetings 225
List of County Medical Societies, Presidents and Secretaries 226

This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

Baker's Modified Milk

MORE and more doctors everywhere are prescribing Baker's Modified Milk because Baker's is prepared especially for feeding newborn and young infants from birth to the end of the bottle-feeding period.

For Toddlers, too, Baker's Is Ideal

When the bottle-feeding period is ended, Baker's Modified Milk in normal dilution** may be fed from a cup or poured on cereal like any fluid milk. Because it provides a nutritionally adequate* formula, containing proteins, carbohydrates, essential fatty acids, minerals and vitamins, Baker's can be used to advantage during baby's entire first year of life.

Many thousands of infants thrive on Baker's —and many thousands of "toddlers" raised from infancy on Baker's continue to deserve Baker's as part of their daily diet. You can continue to prescribe Baker's until the infant reaches the "run-around" age.

POWDER and LIQUID

Made from Grade A Milk (U. S. Public Health Service Milk Code) which has been modified by replacement of the milk fat with vegetable and animal fats and by the addition of carbohydrates, vitamins and iron.

*When fed in normal quantities, provides amounts of proteins, vitamins (except C), minerals and essential unsaturated fatty acids equal to or exceeding the daily recommended allowances of The Food and Nutrition Board of the National Research Council.

**Dilute with equal parts of water.

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES INC.

Main Office: Cleveland, Ohio
Plant: East Tray, Wiscansin

Division Offices: Atlanta, Dallas, Denver, Greensboro, N. C., Las Angeles, San Francisco, Seattle

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

MRS. ELEANOR ROOSEVELT

World-famous wife and mother; Senior United States Representative of the United Nations General Assembly; author, radio and television commentator; internationally respected and admired for her interest in, and understanding of, all peoples.

HONORABLE CHARLES EDISON

Son of the late Thomas A. Edison; former Assistant Secretary and then Secretary of the Navy; former Governor of New Jersey; guiding force as officer and/or director in many nationally known civic, educational and industrial organizations.

MR. RUPERT HUGHES

Author, playwright, producer, poet, biographer, composer; chief assistant editor of the 25-volume History of the World published by Encyclopaedia Britannica; veteran of two world wars; Hollywood writer, Doctor of Letters, director and commentator.

These three great Americans can afford any type of hearing aid at any price. They wear the seventy-five dollar Zenith hearing aid.

BIOGRAPHICAL DATA BASED ON "WHO'S WHO IN AMERICA."

We Take Pride in Announcing

THE MOVING OF OUR OFFICES
TO OUR OWN NEW BUILDING

As a result of the ever increasing acceptance and use of our products and reflecting the growth of our organization throughout the State of Florida we have moved into our new completely air-conditioned building. We respectfully extend a cordial invitation to the Medical Profession to visit our new home.

THE CHANGING OF OUR NAME
TO KEY CORPORATION (Formerly Bever Corporation)

It is our sincere purpose and intention to make KEY CORPORATION a name which will be synonymous with the finest of quality, the newest and latest in drug therapies, and fair and reasonable prescription costs to your patient.

KEY
CORPORATION

ETHICAL PHARMACEUTICALS

300 NORTH EAST 59th STREET
MIAMI, FLORIDA

Formerly Bever Corporation

You don't make an investment before seeking the best advice you can get.

If you are thinking of investing in an x-ray machine the best advice you can get is that of your radiologist. He can tell you the type and make of machine that will best answer the requirements of your particular practice.

Why don't you ask him?

Picker

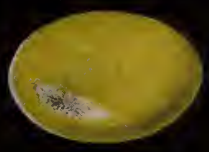
MIAMI 35, FLA., 2759 Coral Way

TAMPA 1, FLA., P. O. Box 30

JACKSONVILLE, FLA., 422 W. Duval Street

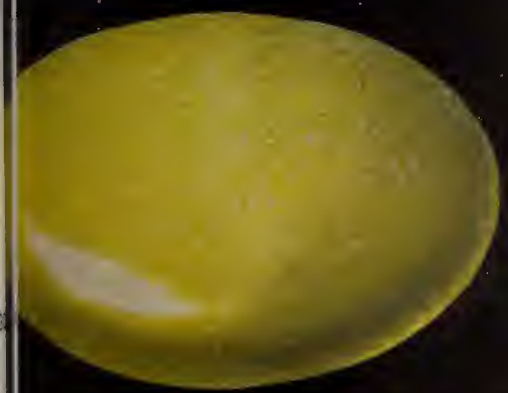
new convenience in broad-spectrum therapy

Introducing new flexibility in broad-spectrum antibiotic therapy with the most familiar and acceptable form of medication for your patients—well-tolerated, rapidly-effective Crystalline Terramycin Amphoteric Tablets (sugar coated) are prepared from the pure, natural antibiotic substance, assuring availability throughout the pH range of the gastrointestinal tract. Will not contribute to gastric acidity.



CRYSTALLINE **Terramycin** AMPHOTERIC SUGAR-COATED **tablets**

Supplied: 250 mg. tablets, bottles of 16 and 100; 100 mg. and 50 mg. tablets, bottles of 25 and 100.



world's largest producer of antibiotics Pfizer

ANTIBIOTIC DIVISION, CHAS. PFIZER & CO., INC., BROOKLYN 6, N.Y.

To cope with emergencies... a needed item for the physician's bag

Anesthesia requirements in accidents and other emergencies make VINETHENE a desirable item in every physician's bag. VINETHENE is a practical inhalation anesthetic for short periods of anesthesia. Administered by open-drop technic, it induces anesthesia rapidly and blandly, and is characterized by prompt recovery with a minimum of postoperative nausea.

Literature on request

VINETHENE®

(Vinyl Ether for Anesthesia U.S.P. Merck)

AN INHALATION ANESTHETIC FOR SHORT OPERATIVE PROCEDURES

Research and Production for the Nation's Health

MERCK

MERCK & CO., INC.

Manufacturing Chemists

RAHWAY, NEW JERSEY

In Canada: MERCK & CO. Limited—Montreal

Corticotropin (ACTH)

Upjohn

The Upjohn Company in early June announced production of Cortisone Acetate, 25 mg. Tablets.

Now we are announcing the availability of Corticotropin (ACTH).

Sterile Corticotropin (Upjohn) is available in two potencies: in vials containing 25 U.S.P. units and in vials containing 40 U.S.P. units.

Upjohn's extensive experience in the research and manufacture of adrenal cortical products has made it possible to provide the medical profession with *both* Cortisone and Corticotropin.

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

A contribution of **Upjohn Research** *to this era of metabolic medicine*

To drain the flooded area
IN CONGESTIVE HEART FAILURE

"In severe congestive failure, our most dependable remedy is the mercurial diuretic . . . Its combinotion with theophylline has been o distinct advonce."[1]

Salyrgan-Theophylline is o highly effective combination of o mercurial diuretic ond theophylline. It moy be given orally in certoin cases.

Salyrgan-Theophylline is extensively employed for the treotment af cardiac and cordiorenol edemo, dropsy of nephrosis and oscites af hepatic cirrhosis. The diuretic response does not "wear out," so that in most coses administrotion moy be repeated os required for years, without loss of efficiency.

Noth,[2] for instance, in discussing a case of Pick's disease, stotes thot the potient "has received obout 450 doses of mercuriol diuretics, neorly all of which were of Solyrgan given [parenterolly] . . . At no time hos he experienced orthopneo, nocturnal dyspneo, or episodes of dyspneo while ot rest. He is still working every day as a banker . . ."

1. Hutchesan, J. M.: Manogement af Cardiac Failure. *Virginia Med. Monthly*, 74:458, Oct., 1947.
2. Noth, P. H.: Pick's Disease: A Record af Eight Years' Treatment with Salyrgan, Ammonium Nitrote, and Abdaminal Porocentesis. *Proc. Staff Meet. Mayo Clin.*, 12:513, Aug. 18, 1937.

Salyrgon, trademark reg. U. S. & Conoda

salyrgan®-theophylline

BRAND OF MERSALYL AND THEOPHYLLINE

Ampuls (1 and 2 cc.) — Ampins (1 cc.) — Tablets

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

Schering

CORTOGEN®

ACETATE

for

CORTISONE

therapy

CORTOGEN

The name Schering has come to stand for pioneering research and leadership in steroid hormone chemistry. Now Schering adds this new important product to its steroid line—available in ample amount to meet all your cortisone needs.

Available as 25 mg. tablets, bottles of 30. For complete information write to our Medical Service Department.

Schering CORPORATION · BLOOMFIELD, N. J.

"PREMARIN"®

Highly effective • Well tolerated • Imparts a feeling of well-being

"PREMARIN"

Most menopausal patients experience striking relief of symptoms with "Premarin."

"PREMARIN"

Estrogenic Substances (water-soluble)

"PREMARIN"

also known as Conjugated Estrogens (equine)

"PREMARIN"

5202 AYERST, McKENNA & HARRISON Limited • New York, N. Y. • Montreal, Canada

This identical triplet allergic to milk

MULL-SOY eliminated symptoms, gave superior weight and growth curves

From the Summary* "A case of gastrointestinal allergy caused by milk in one of a set of identical female triplets is reported. Elimination of milk from the diet of the allergic baby and substitution of soy milk caused a dramatic regression of symptoms, and weight gains which surpassed those of the non-allergic sisters."

From the Conclusions* "Milk allergy need no longer be the difficult infant feeding problem it was formerly. Complete elimination of milk and all milk-containing foods is feasible and desirable in milk allergy and can now be safely and simply carried out. The soy preparation [Mull-Soy] fed to Baby R gave weight and growth curves equal to and better than those of the two sisters fed a cow's milk formula."

*Sobel, S. H.: Milk Allergy in a case of Triplets, *Clin. Med.*, August 1952.

EASY—To prescribe—To take—To digest

a liquid, homogenized, vacuum-packed food for all patients allergic to milk

The **BORDEN** Company,
Prescription Products Division,
350 Madison Ave., N. Y. 17

ACCEPTED Council on Foods and Nutrition American Medical Association

MULL-SOY®

. . . Part of Your "Overall" Picture

Luzier's

Facial Service

If you "know what's good fo
you" you will be delighted wit
our Balanced Facial Service

Call on a Luzier Cosmetic Consultant to assist you in Selection and instruct you i
Application. Her experience, plus your own good taste and judgment, will tell yo
which of our many preparations are perfect for you. From her you will get the specia
attention intelligent women appreciate.

Luzier's Fine Cosmetics and Perfumes

Are Distributed in Florida by:

PFEIFER & PFEIFER, DIVISIONAL DISTRIBUTORS

235 North Main Street

Phone: 3-3636, Orlando, Florida

DISTRICT DISTRIBUTORS

MARTHA MATTHEWS
Box 3754
St. Petersburg, Florida
Phone: 75-8242

LOUISE SMITH
1414 E. Central
Orlando, Florida
Phone: 7520

RUBY FATULA
Box 775
Orlando, Florida
Phone: 9898

REESE T. VERMILYA
Box 2334
West Palm Beach, Florida
Phone: 8069

MAY LUCAS
3404 Cherokee St.
Tampa 9, Florida
Phone: 62-6234

AGNES BRAMLETT
3875 Walsh St.
Jacksonville, Florida
Phone: 2-1575

GERTRUDE SWANGO
Route 4, Box 5-K
Ocala, Florida
Phone: 861 Red

ROBERTA CHATEAUNEUF
1419 West Ave.
Miami Beach, Florida
Phone: 58-7407

New aureomycin minimal dosage for adults—four 250 mg. capsules daily, with milk.

Library, Union League Club, Philadelphia, Pa.

From among all antibiotics, Dermatologists often choose

AUREOMYCIN

Hydrochloride Crystalline

because

Aureomycin provides mild bacteriostasis in diseases of the skin.

Aureomycin has been found effective in pinta, yaws and many bacterial infections of the skin (furunculosis, impetigo, pyogenic dermatitides, sycosis vulgaris and tropical ulcer). It is at present considered preferable to administer the drug systemically in these conditions. Aureomycin is also useful in the control of contributing or secondary infections associated with many dermatoses.

Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. distilled water.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N. Y.

Meat...

and High Protein Therapy in Liver Cirrhosis

A recent critical study of the results of dietary treatment in 68 patients with liver cirrhosis indicates that in its early stages the disease may respond to a nutritious high protein diet.* In most instances, advanced cirrhosis can be stabilized, if dietary and living habits are properly adjusted, permitting patients to return to useful endeavors.

Biopsy was employed in establishing diagnosis of liver cirrhosis and in determining the extent of liver change. Individual patients were followed for from one to three or more years. The basic therapeutic regimen consisted of 200 Gm. protein, 500 Gm. carbohydrate, sufficient fat to render the food appetizing, moderate vitamin supplement (one therapeutic capsule daily), and one-half ounce of brewer's yeast three times daily. Variables included use of a low calorie diet (1,500 calories or less) with 150 Gm. protein, 1 Gm. methionine four times daily, and intravenous injections of liver extract.

Meat can play a significant role in the dietary treatment of the patient with liver cirrhosis. It is an outstanding source of protein of excellent biologic quality, the B group of vitamins, iron, and other essential minerals—nutrients especially important in the therapeutic regimen. Other advantages of meat are its palatability, its stimulating effect upon the flow of digestive juices, and its easy digestibility.

---

*Davis, W. D., Jr.: A Critical Evaluation of Therapy in Cirrhosis of the Liver, South. M. J. *44*:577 (July) 1951.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

American Meat Institute
Main Office, Chicago...Members Throughout the United States

Doctor Harris attends a convention

More medical progress has occurred in his lifetime than in a dozen previous generations. Two-thirds of the medicines he uses today were unknown only ten years ago. As a result of this progress, he has acquired the problem of keeping abreast. He solves it in some measure by attending medical conventions, where he listens to lectures on most recent developments. There, too, he visits technical exhibits and learns of the most recent products from companies whose support helps make these conventions possible.

At one of these, back in the twenties, Dr. Harris was astonished by the announcement that an ancient Oriental herb had received scientific support. This was the beginning of a whole new series of ever-improving medicines. Oddly enough . . .

Lilly

. . . it all began with Ma Huang

In the Chinese village of his birth, young Chen had seen things which assured him that many of the herbs which his people had used for thousands of years were potent remedies. This he believed despite his respect for the Western doctor who would use only drugs from abroad—drugs which were scientifically established. Eventually his ambition to prove his belief brought him to America, where he studied pharmacy and, later, advanced chemistry, physiology, pharmacology, and, finally, medicine. Thus equipped, he returned to China, where he began his experiments with the herb Ma Huang. After isolating the active principle as crystalline ephedrine, he and Dr. Carl F. Schmidt conducted experiments and proved that ephedrine truly had the properties for which the crude drug had been used empirically. Following the well-received presentation of these facts to the 1926 convention of the American Medical Association, Dr. Chen accepted the direction of Lilly's pharmacologic research. There, continuation of his studies was instrumental in developing a series of even better synthetic decongestants. Thus, paradoxically, a small boy's faith in his people's traditions led to progress in modern medicine.

Lilly ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXIX | Jacksonville, Florida, September, 1952 | No. 3

Pitfalls in the Surgery of the Ruptured Intervertebral Disk

William Jason Mixter, M.D.
BOSTON

I am invited here today to talk to you about a structure we hear much of in these days of 1952, but which a short 20 years back was little thought of by most medical men — namely, the intervertebral disk. Your President has probably spent more hours thinking about this cartilage than most of us, for not so many years ago one of his disks, the sixth cervical to be exact, rose up and bit him in the arm. At least that is the way it must have felt, for when an intervertebral disk goes on the rampage, it must feel like being bitten by a rattle snake. Personally, I have never experienced either of these catastrophies, but I have seen many people suffering the agony of an acute attack of pain brought on by a ruptured intervertebral disk. Dr. Murphey and I first met on account of his intervertebral disk. This circumstance makes my interest in this meeting a very personal one, and I can assure you of my deepest and most heartfelt thanks for the privilege of addressing you. It is an honor as well as a great happiness to me to be here as your guest on this occasion.

Medicine, and especially surgery, is full of pitfalls. If it were not so, our work would be easy and our nights would be untroubled by the thoughts of our mistakes. We cannot avoid them all, but if we remember that there are traps and attempt to avoid them to the best of our ability, we will have fewer failures to come back and haunt us. This, I believe, is truer in the treatment of lesions of the intervertebral disk than in almost any other type of surgery. Operations for rupture of the intervertebral disk are in the main operations of election for the relief of pain and slight loss of motor power. Their intent is to return an incapacitated patient to his normal way of life without significant loss of function. We can amputate a man's leg for sarcoma, and he will accept the handicap involved. If his life is saved, the operation is a success. In the surgery of ruptured disk, if we fail to relieve pain completely, or if we further weaken a partially paralyzed leg or arm, the operation becomes at once an absolute failure in the mind of the patient. The patient with a ruptured disk, therefore, is a greater hazard for the doctor than the man with malignant disease.

The first problem in the handling of a case of ruptured intervertebral disk is faced by the physician who first sees and examines the patient. On him rests the responsibility of deciding whether or not this may be a case of ruptured disk and whether treatment should be conservative and without complete investigation. Such a conservative course is based on the probability that the lesion may well be a simple muscle strain, rather than a ruptured disk, and also in the knowledge that in many mild cases of ruptured disk the patient apparently makes a complete recovery following a few days of conservative treatment. The hazard is the difficulty in determining the case in which such a regimen can be employed without risk to the patient, as against the one in which investigation should be carried out without much delay.

It is essential that we remember that there is a pattern in this disease. In the beginning the pattern seldom is definite, but as the days go by even an obscure picture will clear. The real hazard is the case in which the patient needs immediate treatment. What is the pattern? It is governed by the position of the lesion. Rupture is most common in the lower two lumbar disks and the lower cervical disks. If we review the anatomy, the symptoms are more easily understood.

Board of Consultation, Massachusetts General Hospital.
Consulting Neurosurgeon, Beth Israel Hospital.
From the Neurosurgical Services of the Massachusetts General Hospital and Beth Israel Hospital, Boston.
Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 29, 1952.

Normally, the posterior surface of the disk is flat, and there is a considerable space about the root and root sheath containing only loose connective tissue, fat, and blood vessels. There is no compression of the dura and the neural elements contained therein.

Rupture usually occurs as a cleft in the annulus at its weakest point with protrusion of nuclear material and tissue from the annulus into the spinal canal. This mass of disk tissue may be small at first, becoming larger and larger as more material is extruded. Frequently there is tearing of the posterior longitudinal ligament.

The ruptured disk can be likened to a blown-out automobile tire. It has lost its internal pressure and its resiliency. Its side walls are slack, and there is increased mobility between the vertebrae above and below. There is also a foreign body, the ruptured fragment, causing pressure on the posterior longitudinal ligament and the surrounding structures. Such a condition results in nonradiating pain, loss of normal lordosis, and splinting of surrounding muscles. The spine is held stiffly, and there may be listing to one side or the other. The pattern varies, of course, according to the spinal level at which the rupture has taken place, but the mechanics of it remain the same. These may be called the local manifestations of the lesion.

Compression of the nerve elements against the facets and laminae behind by the extruded mass of cartilage will result in radiating pain and loss of function or irritation of the structures compressed, causing the referred and neurological manifestations. Each nerve root has its own pattern of sensory, motor, and reflex change. For example, weakness of the small muscles of the hand, loss of biceps jerk, and pain and sensory disturbance in the thenar side of the hand and arm implicate the sixth cervical nerve root, and the sixth cervical disk; weakness of eversion of the foot, absent ankle jerk, and sensory disturbance and pain over the first sacral dermatome implicate the first sacral nerve root as it crosses the fifth lumbar disk. If the extruded fragment is large, there will be compression of the cord in the cervical region and of elements of the cauda equina in the lumbar region. We must always remember the importance of this double set of symptoms and signs.

One must always suspect ruptured disk in a case in which this double pattern is present, especially if speedy relief is not obtained by conservative measures. I shall not discuss conservative treatment, as that almost invariably is handled by the orthopedist. It is fair to point out, however, that operation for ruptured disk is almost always an operation of election, primarily for relief of pain. For this reason we must always explain to the patient the hazards of surgical treatment and the uncertainties of conservative treatment. It is the patient's pain, not our pain. He alone can evaluate it, and the ultimate decision for or against surgery is in his hands. In order that he may make an intelligent decision, we must be sure that he knows all the facts.

My own opinion is that conservative treatment should not be continued for more than three months, unless the patient's condition has been markedly improved. If his condition worsens, if his pain is extremely severe, or if he shows motor weakness, arrangements should be made for complete investigation without waiting three months. If there is major paralysis or a transverse lesion of the cord or cauda equina, the condition becomes an emergency, and he should be hospitalized at once. Do not procrastinate on the off chance that the patient will improve, and above all, do not waste any time if loss of motor power develops. Weakness of skeletal muscles or sphincters seldom improves, except in part, if it has been present more than a few hours or at most a few days. Pain, even of long duration, can be relieved. Even so, relief is surer and speedier if definite steps are taken before the patient becomes a querulous neurotic invalid.

It is important that we who are called on to study these cases with operation in mind use every means at our disposal to make an accurate diagnosis, and that surgical treatment be withheld by us unless valid evidence is obtained by such study warranting operation. Too many backs are being irretrievably damaged by ill-advised and ill-considered operations. A thorough neurological examination including a sensory examination is essential. If there is the slightest suspicion of a lesion of the pelvis or sacrum, a rectal examination should be made. We are interested in the side of the pelvis and the sacrum as well as in the rectum, prostate, and uterus. I believe that the greatest amount of information can be obtained if the examination of the bony pelvis is carried out with the patient on his side, affected side up, the finger being inserted with the ball of it pointed backward toward the sacrum and coccyx. In obscure cases electromyography may help us to determine with

greater accuracy just which muscles are involved.

The roentgen examination must include both flat plates and, to my way of thinking, routine myelography. Spinal fluid is withdrawn for examination at the time of the myelogram. A previous lumbar puncture may permit the contrast medium to flow into the subdural instead of the subarachnoid space, spoiling the examination.

More than one disk may be ruptured, but such a condition is rare. If the surgeon is confronted with a diagnostic problem that gives evidence of root irritation at two or more levels, he should be most cautious about making a diagnosis of ruptured disk, and he should be particularly cautious about suggesting an "exploratory laminectomy without myelography." Such operations are seldom successful and often make the patient worse.

Illustrative Cases

To bring all this home, let us go over rather quickly a few cases that illustrate some of these errors.

First comes a patient operated on many years ago (case 1). This case occurred in the days when sepsis of the urinary tract killed most patients with nonfunctioning sphincters, as we had little or no knowledge of the modern methods of caring for cases of this type. The patient was a strong healthy middle-aged man who had been treated for three years for spinal arthritis. He had had pain in his back streaming down both legs for that length of time. One day he sneezed and immediately became paralyzed. The paralysis involved both legs, and the sphincters. There was sensory loss up to and including the third lumbar dermatome. All reflexes were abolished below that level. I saw him three weeks later. At operation, it was apparent that the greater portion of the posterior margin of the second lumbar disk lay in the spinal canal. It was removed, but the paralysis persisted, and he died two years later of urinary sepsis. This, of course, is an extreme case, and such a calamity should never occur at the present time.

Another patient, (case 2) seen more recently, will serve to press home the dangers of delay. He is recovering slowly, although his transverse lesion was as severe as that found in the first man. I believe return of function will be satisfactory even if incomplete. This patient, a man of 50, had had intermittent backache for twenty-five years, with pain on bending, coughing, or straining. Four months previously he had had pain in his right leg, and for two days previous to his admission to the hospital there had been pain in both legs. For 26 hours prior to operation he had had a complete transverse lesion including the fourth lumbar dermatome with absent lower extremity reflexes. It is interesting to note that the total protein in the spinal fluid was only 66 mg. per hundred cubic centimeters. You will note that in the flat plate of the lumbar spine the fourth disk shows definite narrowing and that the complete block as shown by pantopaque examination was at the third disk (fig. 1). You will also note the irregular cap. This suggests an extradural lesion. At operation Dr. Ballantine, my associate, found and removed a large free fragment from the third lumbar disk which was blocking the spinal canal. Had the patient not been treated as an emergency with emergency myelogram and operation, his chance of recovery of function would have been poor.

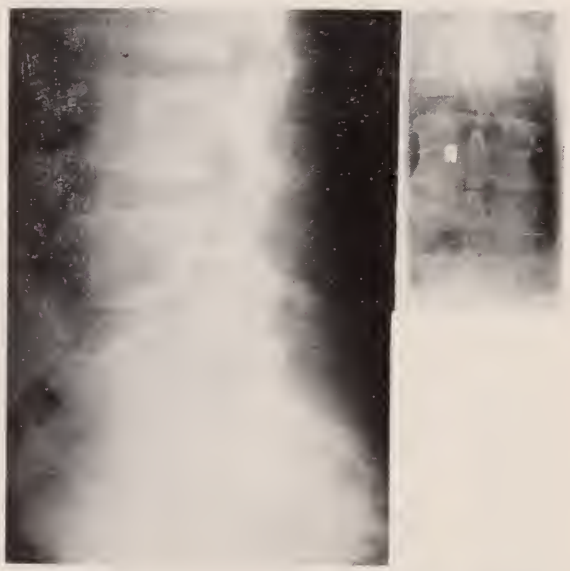


Fig. 1. Case 2. Note narrow fourth lumbar disk and positive myelogram at the third, also irregularity of the edge of the opaque material suggesting an extradural lesion.

Do not be misled by the absence of pain in a given case if paralysis or even moderate weakness is present. Mrs. G. (case 3) was seen primarily because her right foot had been weak for three days and she found great difficulty in driving her automobile. Questioning brought out the fact that she had had a lame back off and on for 13 years. One week before entry, she had experienced some pain in the right leg and great toe, for which she took aspirin. The pain had subsided and was not sharp when she was first seen, but she had numbness in the same area. Examination showed moderate limitation of straight leg raising, partial foot-

Fig. 2. Case 5. Note presence of defect both at the fourth and fifth lumbar disks.

drop, absence of dorsiflexion of the great toe and no loss of reflexes. There was hypesthesia in the fifth lumbar dermatome. She was hospitalized at once. Myelography showed a definite defect at the fourth lumbar disk, and at operation a very large fragment was found compressing the nerve root and right half of the lumbar sac. She made an uneventful recovery except for phlebitis and is now perfectly well with no residual weakness.

An error in proper determination of the level of the lesion may spell disaster. This patient (case 4), powerfully built professional athlete, was operated on many months before I saw him and a hemilaminectomy performed on the fourth lumbar vertebra, apparently without benefit of study with a contrast medium. No evidence of a ruptured disk was found, and he was "decompressed." He was temporarily relieved, but the pain recurred. It was evident on examination that the lesion was at the level of the fifth disk. The symptoms were bilateral, but more pronounced on the right. Roentgenograms revealed the fact that he had a decided list beginning at the fifth disk, and myelography showed a pressure defect at that level. The total protein in the spinal fluid was 87 mg. per hundred cubic centimeters. Determination of the level of the lesion was complicated by the fact that the first segment of the sacrum was lumbarized, giving him what at first glance appeared to be six lumbar vertebrae. Operation at the proper level exposed a large free fragment, which was removed and fusion done, with relief of symptoms.

We have spoken of the presence of two ruptured disks. Such a condition is rare in my experience, but it does occur. Mrs. L. (case 5) had had pain in the back for three years following an automobile accident. The pain grew worse, and finally she was put in double leg traction, but with only temporary relief. When first seen, she had the classical signs of ruptured lumbar disk with absence of both ankle jerks, but in addition she had a right foot drop. Myelography revealed defects at both the fourth and fifth lumbar levels (fig. 2), and rupture of both of these disks was confirmed at operation. She has done well, but still has some weakness of the right foot, two years after the operation.

Even if all the criteria for a tentative diagnosis of ruptured disk are not present, one may suspect the possibility of it if some positive evidence is present. We all know from our case histories that there may be a period of weeks, months, or even years during which the patient has repeated incapacitating attacks of pain or is unable to hold his job on account of pain and a so-called "weak back or weak neck." If a positive diagnosis can be made during this time, the patient can be saved a long period of invalidism. This necessitates careful, repeated examination in such a case. A temporary loss of the ankle jerk, weakness of eversion of the foot, sensory deficit, unilateral interference with straight leg raising, or even an increase in the frequency and severity of pain under adequate conservative care, may be enough to justify myelography. If positive, this will change suspicion to certainty. We now have a few cases of this sort, though none in the cervical region.

This patient (case 6) had a history of periodic low back pain of eight years' duration, with the attacks becoming more and more frequent and severe. At times there had been slight radiation of pain to the back of the right thigh. There was a slight list to the left with limitation of forward bending. Straight leg raising was 60 degrees on the left and 45 on the right. There was no deviation from the normal in strength, reflexes, or sensation. Roentgen examination showed narrowing of the fourth lumbar disk, and myelography showed a bilateral defect at that level (fig. 3). The total protein was 66 mg. per hundred cubic centimeters. At operation a free fragment anterior to the posterior longitudinal ligament was found and removed. As there was localized abnormal mobility, a fusion was done. This is a recent case, but so far the pain has been relieved.

In considering unexplained pain in the areas supplied by the nerves leaving the cord in the cervical region, we should avoid the error of lay-

ing too much emphasis on lesions of the brachial plexus, and neglect of the spine and cord. Scalenus anticus syndrome, for example, is a dangerous diagnosis unless the intervertebral disk has been proved innocent by myelography and examination of the spinal fluid. It is true that scalenotomy is not serious, but unsuccessful surgery is to be avoided. That operation, therefore, should not be advised unless there is a well marked circulatory component or ruptured disk has been ruled out. In my own practice, scalenotomy is a rare operation and almost never advised unless cervical myelography gives negative results.

I have not discussed in detail the symptoms and signs of ruptured intervertebral disk, and do not propose to do so. Nor shall I review carefully laboratory aids in diagnosis. A few words, however, concerning the examination of the spinal fluid will not be amiss. A completely normal spinal fluid does not rule out the presence of a ruptured disk, although we usually expect to find a moderate increase in the total protein determination. A very high protein should suggest to our minds the possibility of a tumor or a lesion which blocks the spinal canal.

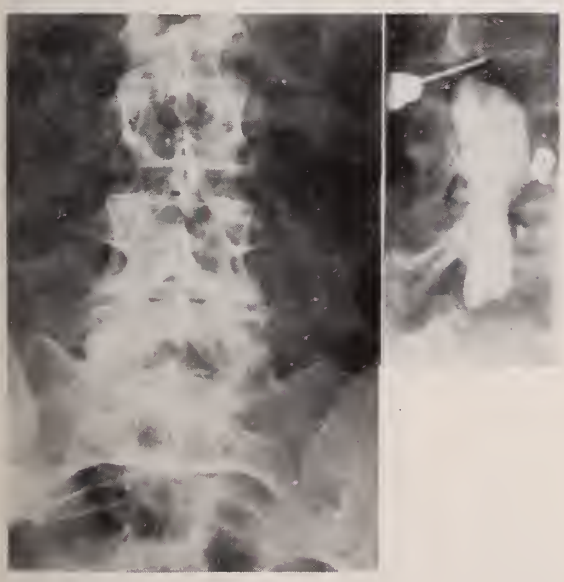


Fig. 3. Case 6. Typical ruptured disk, but with very slight radiation of pain.

In the examination of the usual x-ray plates of the lumbar spine, one should be suspicious of a narrowed disk, but one should not regard such a finding as positive evidence of rupture. The sixth cervical disk will be found to be narrowed in many instances, and the finding of a ruptured disk without narrowing is not uncommon.

One should use great caution in making a positive diagnosis of ruptured disk, unless the symptoms and signs follow the usual pattern, including positive myelography. The disparity, however, between the size of the bony canal and the lumbar sac at the level of the fifth lumbar disk may be sufficient to permit the presence of a ruptured disk with an apparently normal dural sac. This condition occurs in about 5 per cent of cases. If, therefore, all other criteria are present, exploration of the fifth space may be indicated in the face of a myelogram giving negative evidence.

Some surgeons look upon this fault in myelography as so important that they are willing to dispense entirely with the procedure. I do not think that their position is justified. Surgery of the intervertebral disk is major surgery, and the penalty of error is severe. Anything that we can do to minimize errors in diagnosis and errors in the level of the lesion is of value. Myelography carries with it certain dangers and certain discomforts. Even so, what we obtain from it may far outweigh these factors. I have operated on a few patients previously operated on elsewhere, without myelography, for ruptures of the fourth or fifth lumbar disk, and demonstrated unsuspected tumors of the cauda equina. These patients would have been saved many months of invalidism had myelography been used in the first place.

The importance of proving the diagnosis of ruptured intervertebral disk and of ruling out some other lesion of the spinal canal should be emphasized.

Mrs. E. (case 7) had a long history of backache and about 1943 there developed pain in the left leg streaming down to the foot. A year later she was operated on elsewhere for ruptured intervertebral disk. She was improved and was comparatively pain-free for a few weeks, but the old pain recurred as soon as she resumed her work. She was considered neurotic, later treated for arthritis. When we saw her some five years later, there had developed pain in the right leg as well as the left, a spastic paresis, and sensory impairment greater on the left than on the right. Myelography revealed a partial block at the upper edge on the twelfth dorsal vertebra (fig. 4), and the total protein was 204 mg. per hundred cubic centimeters. Operation revealed a large meningioma, which lay in part within and in part without the cord at the level of the eleventh dorsal vertebra

Fig. 4. Case 7. Meningioma. Note smooth cap, which is indicative of an intradural lesion.

on the left. It was removed with considerable difficulty. Had the diagnosis been made earlier, she would have been saved a great deal of suffering. She still has some pain and spasticity, some four years after removal of the tumor.

The question of fusion as a part of the operative treatment of ruptured intervertebral disk in the lumbar region is still an open one and you will find a wide difference of opinion as to the advisability of including it as part of the initial operation. In my own cases, I prefer not to be dogmatic, but to decide each case on its own merits. We must all agree that the addition of fusion increases the mortality and the morbidity of the operation. It will, if successful, stiffen the fused portion of the spine, but it will not prevent the motion of the root sheaths and the enclosed root when the leg is moved. The trauma to the soft tissues of the back and to the bony structures is greater if a fusion is done, and in certain instances, abnormal mobility will develop later above or below the grafted area. I grant you that a ruptured disk in the lumbar region is abnormal and has lost its cushioning function. On the other hand, firm scar tissue and at times a bony bridge may make a fusion unnecessary. A bone graft, therefore, should not be considered unless abnormal mobility can be demonstrated, or in certain special instances. In this exceptional group, I would include young healthy persons whose livelihood necessitates the lifting of heavy weights, or whose spine shows definite evidence of structural weakness. I do not believe that in elderly people and those who are poor surgical risks fusion should ever be carried out, nor do I believe that in cases of cervical or dorsal disk rupture there is need for this added support.

The need for secondary fusion has been considered evidence of failure in intervertebral disk surgery. I take issue with this attitude. The necessity of secondary fusion is rare — probably less than one in 10. If the operation has been discussed thoroughly with the patient, after careful study, then we need have no hesitation in advising the simpler operation with the definite possibility of secondary fusion at a later date. As the patient has been made aware of this possibility, there should be no cause for dissatisfaction on his part.

Operations for intervertebral disk rupture give plenty of chance for trouble from beginning to end, and neglect of even some of the small things may spell the difference between success and failure. Such surgery is not to be done with an untrained team with the bone instruments commonly found in the instrument room of the usual community hospital. We have advanced a long way since the early days of disk surgery. In those days we did a wide laminectomy and after painstaking search we would come up with a small mass of inspissated cartilage that we called an enchondroma.

Now we remove the ligamentum flavum, trim away a little bone, or possibly remove the laminal arch on the affected side. Seldom is it necessary to do more than that. Such an approach is made possible only by the use of special instruments and pinpoint accuracy of diagnosis.

Perhaps before speaking of the snares to be encountered during operation, we should review the technic employed in 2 typical cases, 1 cervical and 1 lumbar.

The patient in the cervical case (case 8) had a typical history and typical findings on examination for rupture of the sixth cervical disk. Myelography showed a small but constant defect at this level (fig. 5). He was operated on sitting up with head bent forward. The exposure was unilateral and at first only a partial laminectomy was performed. Exposure of the mass and root sheath was inadequate; therefore, hemilaminectomy was carried out. The protruding mass proved to be part torn

cartilage and part bony shell, and with considerable difficulty it was trimmed away until the root sheath was decompressed without opening the dura or sacrificing more than the inner edge of the facet.

The patient in the lumbar case (case 9) also had a typical history and examination. Myelography showed a typical defect. As no fusion was contemplated, the patient was placed on the table with the involved side up and the table broken to give as much space as possible between the laminae. Here again the approach was unilateral without sacrifice of continuity of bone. Only a little of the articular facet was trimmed away, but great care was taken to remove all of the ligamentum flavum beneath it. On gently retracting the nerve root toward the midline the typical rounded mass of disk tissue was exposed and removed, together with any torn fragments lying within the cavity of the disk. Care was taken not to pry the vertebral bodies apart and only torn disk tissue was removed from the cavity of the disk.

Fig. 5. Case 8. Ruptured disk at the sixth cervical level on the left. Note that the list begins at that level and also the small but constant defect demonstrated by myelography.

We all know the tragedy of the incomplete operation for cancer of the breast when some unskilled person does a simple amputation without removal of axillary glands, pectorals, or sufficient margin about the growth. We have all seen cases such as this and we can realize only too easily why they occur. Exploration of the spinal canal is comparatively easy at the first operation, but is always difficult and unsatisfactory at the second, on account of scar tissue formation in the epidural space. As in the cancer patient, we must be sure that nothing is overlooked the first time. We must remember that exposure of the lesion must be adequate, but that we should preserve as far as possible the continuity of the laminae and the functional integrity of the joints between the facets.

Hemostasis is important for it is impossible to do good surgery in a wound that is bathed in blood. Here one must watch many angles. Anesthesia must be perfect. The position of the patient on the table should be carefully arranged with two points in mind — to give as much spreading of the laminae as possible, and at the same time to eliminate pressure on the abdomen. Too few surgeons and anesthetists realize the wide communication between the veins of the abdomen and those of the epidural space and the importance of minimizing intra-abdominal pressure. Leakage of blood into the epidural or subarachnoid space during or after the operation causes a great increase in scar tissue, and a nerve root buried in cement-hard scar will of necessity be a source of pain or loss of motor function. Nerves will not tolerate rough handling; therefore, the retraction of the root sheath to expose the disk margin beneath it must be gentle, but it must be sufficient to permit proper inspection and treatment of the lesion present. These are all general surgical principles, but in this operation they are of far more importance than in most surgical procedures. To slight them may well mean failure in the individual case, and one never has the chance to operate on this patient again through an unscarred field.

The search for a hidden and elusive fragment of disk tissue is difficult at times. One finds perhaps a narrowed disk with an opening in its margin and no fragment apparent either in the spinal canal or within the cavity of the disk. Where is it? The nerve root is back against the articular facet and yet there is no fragment. We must look toward the midline both in front of and behind the posterior longitudinal ligament. We must look above the disk, below it, and out in the notch in front of the root sheath. We must level the table to be sure that the fragment is not within the disk cavity when the table has been "broken" to permit best exposure. Sometimes such a concealed fragment will literally pop out on leveling the table. Perhaps the most thoroughly concealed fragment that I remember was in the case of Mrs. R. (case 10). This patient presented the classical picture of a ruptured disk at the fourth lumbar disk on the left (fig. 6). She had been operated on twice

Fig. 6. Case 10. Ruptured fourth lumbar disk. The fragment lay entirely within the root sheath.

previously. There was a cleft in the disk margin, and an indefinite mass could be felt. Exploration and retraction of the root sheath failed to reveal it. Finally, spinal fluid was noted coming from a small rent in the anterior surface of the root sheath above and lateral to the axillary pouch. On opening the sheath the fragment was found intimately adherent to the fibers of the root. It was dissected out and the scarred root fibers severed. She made a complete recovery except for some numbness and slight weakness of dorsiflexion of the great toe.

Another fault that may creep in to plague us later is our own desire to find a ruptured disk when we have made that diagnosis. It is not enough to say, "This disk must be diseased; therefore, I will open it." We should prove beyond a doubt that the disk under inspection really is at fault. In the usual case with unilateral symptoms we must prove nerve root compression. Normally there is a space filled with loose connective tissue and fat from 1 to 3 mm. in width, between the nerve root and the articular facet. If this space is preserved and we cannot demonstrate pinching of the root or definite softening of the annulus, we should not meddle with the integrity of the disk. A concealed disk, so-called, may occur, but to cause nerve root symptoms it must compress the root by bulging backward against it. To open an intact, normal disk is a fault of which we seldom should be guilty. I must confess I have done it myself, but I always look upon it as a grave error, for by so doing we have converted a normal useful disk to one that is ruptured.

You will remember that the aorta and vena cava cross the fourth lumbar disk, hugging it closely, and the common iliac vessels bear the same relation to the fifth disk. Curetting of the inner surface of the annulus or even using a pituitary rongeur on it is fraught with danger unless it is done very lightly and carefully. If any of these vessels are injured, an operative fatality is probable. A few of these terrible accidents have been reported, and it is probable that there have been a good many more.

We have spoken previously of the neoplasms of the cauda equina. We must also remember the abnormalities of the vertebrae themselves. Old fracture of lamina or pedicle, varix, hemangioma of the vertebral body, metastatic malignant disease, or chronic inflammatory disease may lead us astray. Such cases as these are easily confused with ruptured intervertebral disk, much to the chagrin of the surgeon. One must be on the watch for such lesions if adequate disease of the intervertebral disk cannot be demonstrated.

The after-care in a case of ruptured intervertebral disk is of great importance. Too often the patient in such a case is carried through the immediate postoperative phase and then dismissed to the family physician without proper follow-up and without proper instruction concerning his future activities. We are courting trouble if we tell the patient that now the protruded fragment has been removed, and that he is going to be a well man and can do anything he wishes as soon as the wound is well healed. No family physician will complain if the surgeon follows these cases for a year or even longer. Each patient should be told postoperatively that his spine is not as strong as before it was damaged, whether a fusion has been done or not. He should be cautioned against lifting extraordinarily heavy weights, even after recovery is complete. He should be taught how to lift properly by bending the knees and lifting with the thigh muscles. His back muscles are atrophic and tight. Setting exercises should be started as soon as safe, and later, depending on the individual patient and the type of operation performed, limbering exercises should be added. Here in Florida you have an advantage over us in the North, as swimming is an ideal exercise to strengthen the back muscles. If we explain to our patients that their muscles are like lamb chops, and we wish to make them sirloins, the simile may be remembered. I have a few patients who are perfectly

well years after operation, as long as they continue their exercises, but who get into trouble if they give them up.

Summary

If I were to be asked to sum up the most important pitfalls in the surgery of the ruptured intervertebral disk, I think I would name them about as follows:

Pain is the outstanding feature in most cases; therefore, do not force operation on an unwilling patient, or without sufficient trial of conservative treatment. If evidence of paralysis is present, however, even though partial, immediate operative intervention should be urged.

Surgery of the intervertebral disk is serious surgery, and operation for recurrent symptoms may be extremely unsatisfactory. Nothing, therefore, should be left to chance, either in the study of the case or in the operative procedure.

Finally, follow each patient for weeks, months, or years, as the case may be, to be sure that nothing in the after-care is left undone.

I have touched on a few of the pitfalls one meets in treating rupture of the intervertebral disk. There are many others. I would urge the thoughtful consideration of the industrial accident case, the soldier with a lame back, and the neurotic person. Today they are unsolved problems. Perhaps ten years from now we will have the answers.

Surgery is an art and, as in painting, he who follows the precepts of those who have gone before without thoughtful consideration of his subject, can only turn out passable results. He who strives toward the impossible goal of perfection must be adept in every technic of his art, ready to use each or all of them as the case may require.

My time is up, and if I have given you food for thought, my assignment from your President has been carried out.

319 Longwood Avenue.

Experiences with the Therapeutic Use of a Long-Acting Corticotrophic Preparation

Carlos P. Lamar, M.D.
Miami

Maximum therapeutic effectiveness from aqueous ACTH requires that it be administered either at six hour intervals or, as proposed by Thorn and his co-workers,[1] by slow intravenous drip during a period of eight hours every day. In ambulatory patients, these methods of administration are obviously impractical. Even in hospitalized patients, the need for extra nursing attention and the inconvenience of the frequent injections make it too complicated a procedure to become of general and frequent application.

Wolfson and his co-workers have tried to produce a long-acting ACTH preparation suitable for prolonged and ambulatory treatment. They reported in June 1950 on an ACTH gelatin mixture[2] and in June 1951 on another ACTH preparation with aluminum monostearate and sesame oil.[3] Both preparations appeared promising, and the manufacturers released the former in the fall of 1951 for the first time for general use.

In this paper, I wish to present some preliminary observations on the use of the gelatin ACTH preparation (Armour's "ACTHAR-Gel") in a varied group of 4 cases representative of four different conditions in which this therapy is indicated and which were closely studied for periods of over five months of observation.

Report of Cases

Case 1. — Status Asthmaticus, Congestive Hepatomegaly, Amenorrhea. Mrs. M. O., aged 23, came from her home in North Carolina on Oct. 9, 1951 in severe status asthmaticus of several weeks' duration, which appeared refractory to injected or inhaled solutions of epinephrine and to orally administered antihistaminic therapy. In addition, she complained of persistent pain in the right upper quadrant of the abdomen. She was considerably distressed also about the fact that no menses had appeared since the birth of her first baby four and one-half

Director, Department of Endocrinology, Jackson Memorial Hospital, Miami.
Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 28, 1952.

months previously. There was a history of asthmatic attacks since childhood, a spontaneous abortion in August 1949 and irregular menstruation with bouts of dysmenorrhea and occasional menorrhagia up to the last and successful pregnancy.

On physical examination, the liver was enlarged and tender down to 4 fingerbreadths below the costal margin. The skin was dry and scaly from a form of ichthyosis she had suffered from early childhood and which at this time was more intense than ever before.

Inhalations of isopropylarterenol (Norisodrine 10 per cent) powder produced relief of the intense dyspnea for about two to three hours at a time, but no satisfactory permanent improvement was obtained. Sedatives and antihistaminic medication along with vitamins and other supportive therapy were also administered. She refused hospitalization.

On October 18 ACTHAR-Gel became first available to us, and she received a first dose of 60 units intramuscularly. The circulating eosinophil count prior to the injection was 388 per cubic millimeter by the Randolph method.[4] The same dose was repeated in 24 hours. Forty-eight hours after the first dose she reported some improvement, and the circulating eosinophil count had dropped to 137.

From then on improvement continued to increase rapidly, and the circulating eosinophil counts remained lower than one third of the pretreatment levels for the next 11 days. The ACTHAR-Gel was administered daily in decreasing doses for a total of 450 units in 13 days.

During that time the hepatomegaly subsided almost completely, the skin improved, and there developed a mild Cushing's syndrome with a gain in weight of 11½ pounds (5.23 Kg.) Daily administration of ACTHAR-Gel was discontinued after October 30. By November 3 there was a moderate increase in the circulating eosinophil count and a slight return of symptoms, but she was well enough to return to her home in North Carolina the next day carrying with her a small supply of ACTHAR-Gel which she used by intramuscular injections as marked in figure 1. By December 3 the menses returned, and there was complete remission of the status asthmaticus. She has written several times since, reporting continued improvement and gradual disappearance of the Cushing's syndrome features.

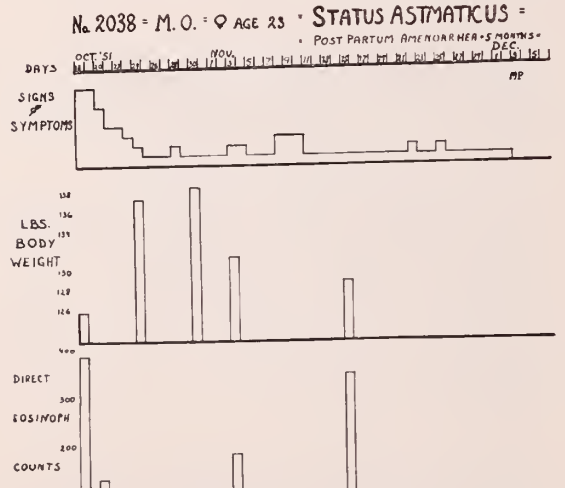


Figure 1.

The menses are regular, the liver has not become enlarged again, and the skin is back to the previous usual state. Although a prolonged course of ACTH seems advisable in an attempt to investigate its possible effects upon the scaly dermatosis, she has not been able to proceed with it up to this time.

It seems evident that ACTHAR-Gel administered by a single intramuscular dose daily in this case produced a satisfactory response, analogous to that usually occurring in similar cases treated by ACTH injections every six hours around the clock.

CASE 2. — PEMPHIGUS VULGARIS. Mrs. W. J., a 47 year old housewife, had been under treatment and observation for several years with various "functional" complaints related to moderate adult hypothyroidism, ovarian dysfunction and hepatic insufficiency. On Nov. 9, 1951 she consulted me about a vesicular rash which had been present for about 12 days on the internal aspect of the left thigh. She had been taking no medication and had been in excellent health for several months, but on her last routine check on October 19 I had remarked that the percentage of eosinophils in the differential counts had been increasing gradually from about 2 per cent a year before to 5 per cent six months previously and 9 per cent on September 26.

The skin lesions were painless, but accompanied by pruritus and a burnlike sensation, and some of them appeared to be drying out. The largest ones were about 5 mm. in diameter. They were of a red wine color and filled with a pinkish exudate. Other lesions showed denuded red skin after the blisters had broken and dried up. General examination was noncontributory, and the patient felt well. There was no elevation of temperature.

Nothing but careful observation was advised at the time. She returned on November 21 with an extension of the rash to the anterointernal aspect of both thighs. There were numerous lenticular lesions from 4 to 18 mm. in diameter, consisting of eroded surfaces of wine red color which had resulted from the breaking up of the blisters, with desquamation of the loose epidermis. Others were still in the blister stage. The lesions extended from the lower third of the thighs up to both labia majora.

The hemoglobin estimation was 12.0 Gm., the red blood cells numbered 4.1 million and the white blood cells 11,900 per cubic millimeter with 73 per cent neutrophils, 19 per cent lymphocytes, 3 per cent mononuclear leukocytes and 5 per cent eosinophils. The direct circulating eosinophil count was 268 per cubic millimeter.

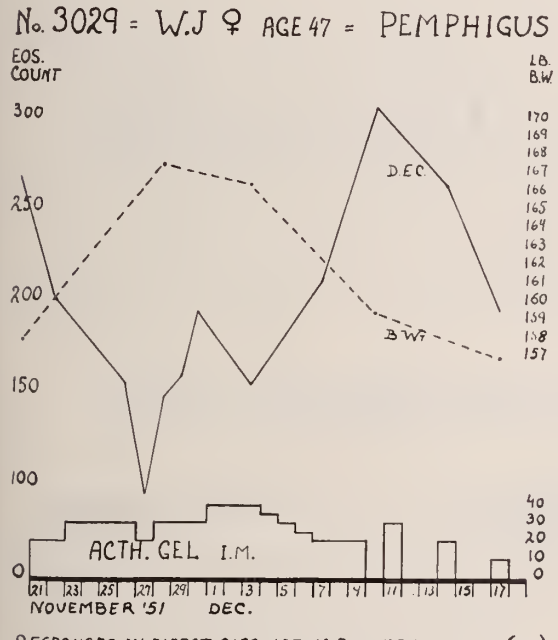
A diagnosis of pemphigus vulgaris was made.

Previous studies of various types of pemphigus have associated this skin condition with adrenal cortex disturbances,[5,6] and since ACTH has become available, it has been used successfully in this condition. Homburger, Bonner and Fishman[7] reported 1 severe chronic case in which ACTH was administered in daily doses totaling 75 and 100 mg. in repeated courses. Each course induced a remission of symptoms which paralled changes of the circulating eosinophil count levels. Rubin[8] used 10 mg. of ACTH, administered intramuscularly every six hours, in the treatment of a case, with a complete remission after one month.

The patient received 20 units of ACTHAR-Gel intramuscularly for two consecutive days with a drop in the circulating eosinophil count to 201 per cubic millimeter and little change in the rash. The dose was then increased to 30 units daily. On the sixth day there were practically no new lesions, and the circulating eosinophil count was down to 156 per cubic millimeter, and to 95 on the following day. The rash appeared then almost arrested. The dose was reduced back to 20 units on that day, and a new crop of lesions appeared on that night with an increase in the circulating eosinophil count to 148 the next day. The rest of the story may as well be read on the graph in figure 2. Each increase in the circulating eosinophil count preceded the appearance of new bullae, but each new crop was much smaller than the previous one. Despite the great increase in the circulating eosinophil count, reaching on December 10 a level of 306 per cubic milli-

meter, by that time no new lesions were present and the process was in frank remission. The last three doses of ACTHAR-Gel were administered in order to taper off the treatment. The remission has persisted up to this date. A mild manifestation of Cushing's syndrome developed and subsided gradually after treatment was discontinued.

In this case the clinical response to ACTHAR-Gel appeared excellent and it seemed to parallel the variations in the circulating eosinophil counts. As there are forms of pemphigus vulgaris in which no involvement of systemic health becomes apparent and which may subside spontaneously, it is not possible to conclude positively that ACTHAR-Gel was a definite factor, but one may at least assume that perhaps it did prevent the syndrome from becoming the chronic and more severe form more frequently encountered, which is usually highly resistant to treatment.



RESPONSES IN DIRECT CIRCULATING EOSINOPHIL COUNT (——) AND IN BODY WEIGHT (- - - -) TO "ACTHAR-GEL"

Figure 2.

Case 3. — Lupus Erythematosus Disseminatus. Sister J. McD., a 38 year old Catholic nun, was admitted to Mercy Hospital on Oct. 27, 1951, complaining of recurrent episodes of substernal pain. She had had cardiologic studies by two competent cardiologists, which gave negative results, when first seen by me on November 1. Recent symptoms included aches and pains in diverse areas of the body, especially various joints, globus hystericus, claustrophobia, periods of moodiness alternating with periods of exhilaration, severe apprehension, insomnia and other evidences of disease which were suspected of being psychiatric in origin. Her past history revealed no serious illnesses until nine years previously when severe arthritis of the back, wrists and feet developed.

There was radiologic evidence of unusual destruction and absorption of bone at various affected joints and of cloudiness of the antrums. She was slender and pale and appeared undernourished. There was a moderately severe anemia, chronic febriculae and also frequent episodes of epigastric distress suggestive of cholelithiasis, but radiologic studies of the gastrointestinal tract and gallbladder gave negative results.

On November 11, I observed a typical "butterfly rash" consisting of a slightly scaly erythema with prominent superficial blood vessels, occupying the bridge of the nose and the cheeks. She stated that she had noticed it off and on for several years, but had not thought of mentioning it before to any of the various physicians she had consulted. L.E. cells were demonstrated by incubating the patient's plasma with a suspension of a donor's heparinized blood cells on November 14, and on that day ACTH therapy was begun by the intravenous method advocated by Thorn and his Boston group.[1] Twenty units of ACTH was administered in 1,000 cc. of normal saline intravenously during a period of eight hours. Because the patient resented the prolonged discomfort, it was possible to administer the ACTH in this fashion only every other day, but the results were so encouraging that it was decided to follow it with ACTHAR-Gel intramuscularly.

As in the previous 2 cases, circulating eosinophil counts paralleled clinical improvement. After eight daily doses of 20 units each, administered intramuscularly, she reported complete cessation of pain in the joints for the first time in nine years, and the butterfly rash had again disappeared. The circulating eosinophil count, originally 356, had dropped to as low as 22, but it never reached zero as reported by other authors. Discontinuation of the ACTHAR-Gel injections after 13 days of treatment was followed by a moderate increase in the circulating eosinophil count and an intense progressive recurrence of pain in the joints, epigastric distress and nervous symptoms.

A single dose of 40 units on December 3 was followed by a sharp drop in the circulating eosinophil count and considerable improvement in the clinical picture. For several weeks afterwards, attempts were made at finding the minimum maintenance dose and widest possible intervals between injections. Special efforts had to be made to avoid the production of a Cushing's syndrome in this case because of the intense fears against the side effects of ACTH and cortisone which this patient harbored from her own readings on the subject. At no time did there develop more than an almost imperceptible rounding of the face, and the gain in weight was never remarkable. For the first two months the weight varied between 112 and 116 pounds and eventually reached a maximum of 124 pounds on April 11 after 128 days of ACTH therapy followed by 22 days of orally administered cortisone.

She was discharged from the hospital for ambulatory care on Jan. 10, 1952 on the fifty-eighth day of treatment, in almost complete remission. She was then receiving an injection of ACTHAR-Gel three times weekly according to the results of the circulating eosinophil counts, determined each time. The doses varied between 20 and 40 units, and a satisfactory clinical control was maintained with gradual gain in strength and improved mental condition. When it was attempted to reduce the injections to twice weekly, there was an aggravation of symptoms and return of pain in some joints along with reappearance of the butterfly rash. After a while she observed that on week ends she was worse, from Saturday until a few hours after the next injection on Monday. When on the one hundred second day of treatment she again appeared practically free of symptoms, the next dose was reduced from 30 to 20 units and then to 10 units for the next two doses. Severe return of joint pains, some fever and the rash reappeared.

This therapy was carried on for a total of 128 days. She received a total of 1,240 units of ACTH during that period of time.

Despite this improved method of administering ACTH, there was still the inconvenience of the injections and no complete and permanent remission, and it seemed evident that she should receive this type of therapy indefinitely. Either the adrenal cortices must be continuously stimulated by ACTH or she must receive exogenous cortisone. There is no other therapy of comparable effectiveness available for this condition, and permanent remissions are extremely rare. Attempts to dissuade her from her fears of cortisone were finally successful in March, and she was persuaded to try oral cortisone therapy.

Cortisone acetate tablets were started cautiously on March 21, the one hundred twenty-ninth day of treatment. One-half tablet or 12.5 mg. was taken orally that evening at bedtime. Next day she reported an intense reaction

characterized by swelling of the face and arms with severe nervousness and insomnia which lasted over 18 hours. Despite this reaction she was advised to take another ½ tablet that night. Another reaction ensued, similar in character, but much milder and of shorter duration. She agreed to keep on taking that same dose every 12 hours. It soon became evident that the dose was insufficient because, although the circulating eosinophil counts did not rise significantly, the joint pains, the rash and febriculae gradually returned to severe intensity. Since the last date recorded in figure 3, the dose of cortisone has been increased up to 50.0 mg. (two tablets) every eight hours.

The long range effects of orally administered cortisone and, for that matter, of long-acting ACTH have not yet been clearly determined. It is still questionable whether a satisfactory remission may be maintained with orally administered cortisone acetate in this patient by utilizing doses small enough to avoid the production of a Cushing's syndrome. The weight is increasing now at a more rapid rate, and the face is becoming distinctly rounded, along with the appearance of fine acneiform lesions on the previously pale and clear skin.

On the other hand, during the time the patient was under ACTHAR-Gel therapy, adequate relief of the multiple symptoms was obtained for prolonged periods of time when 30 to 40 units was injected every third day. The signs of Cushing's syndrome were then minimal at all times.

Addendum

At the time of correcting galley proofs of this paper (July 18, 1952) this patient is again under ACTHAR-Gel therapy. The trial with oral cortisone started on March 21, 1952 was carried on through May 2 with various doses without ever obtaining satisfactory remission but inducing intense Cushingoid signs accompanied by severely distressing symptoms: Nausea, bloating, headaches, diarrhea and dizziness along with intensified arthritic pains. Since May 3 she has again been taking injections of ACTHAR-Gel, at first daily, then every other day and again daily. At the present time she has been in satisfactory remission for about 25 days on daily doses of 40 units. Her eosinophil count was zero for the first time on July 11. Despite the daily and higher dose of ACTHAR-Gel, Cushingoid signs are absent, and the weight has remained fairly steady, varying between 122 and 127 pounds. She has been under continuous treatment now for 248 days.

CASE 4. — "MIXED" RHEUMATOID ARTHRITIS. Miss B. W., a 16 year old high school student whose mother has been for many years the victim of severe degenerative osteoarthritis which has deformed her hands, elbows, knees and feet, in the summer of 1951 experienced acute rheumatoid arthritis of the hands, knees and feet with great inflammatory reaction. For about one year previously she had complained of pain occurring at various joint locations for short irregular periods of time and without phy-

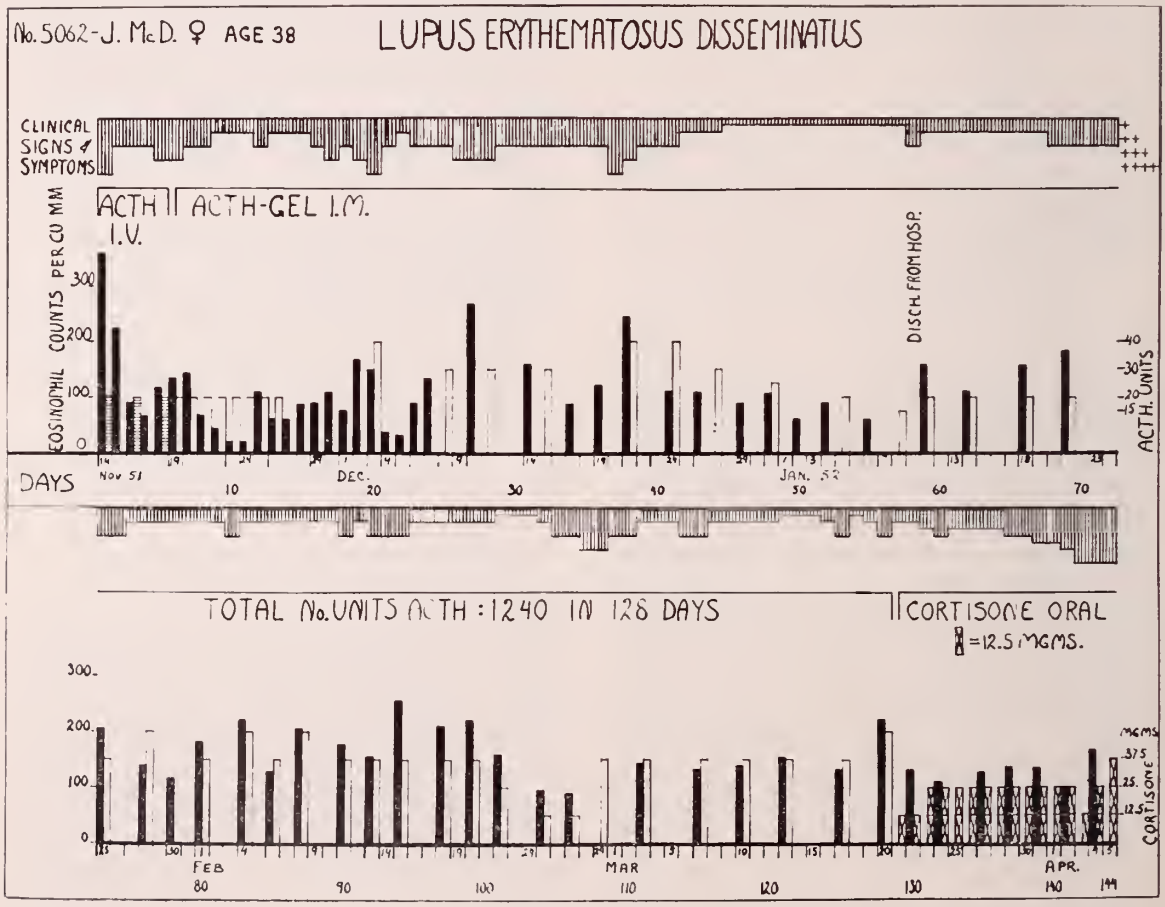


Figure 3.

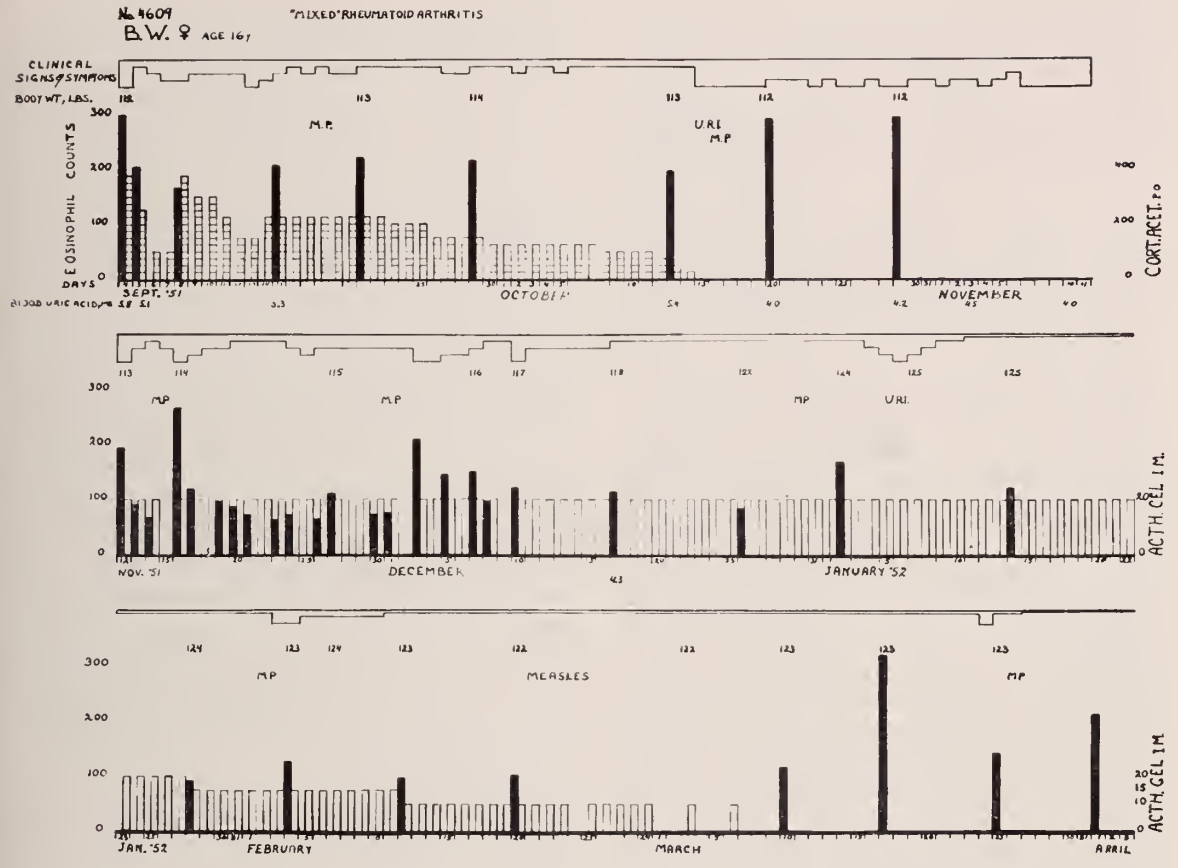


Figure 4.

sical signs. The previous physical, radiologic and laboratory examinations had always given negative results, but this time elevated sedimentaton rate, leukocytosis, and a clinical picture which was fairly typical were present. In addition, there were elevated levels of blood uric acid, and on various occasions the pain and appearance of the first metatarsophalangeal joint on one or the other foot was typical of podagra.

Salicylate therapy gave a limited response, and pregnenolone with ascorbic acid injections administered elsewhere had elicited no response at all.

Under colchicine therapy there was a reduction in the swelling and pain of the big toe joints, but other affected joints elsewhere did not show appreciable improvement.

On Sept. 4, 1951 oral cortisone therapy was begun, along with salicylates, colchicine and the physical therapy measures previously established. She received five tablets or 125 mg. of cortisone acetate every eight hours on the first day and every 12 hours on the second day, when clinical improvement became remarkable. The dose was then reduced further to 50 mg. every 12 hours for the next two days, but it had to be increased again on the fifth day. The chart (fig. 4) shows the doses required to maintain a moderate degree of clinical improvement. The circulating eosinophil counts showed only a moderate reduction, which at no time reached 50 per cent of the initial count. A decided appearance of Cushing's syndrome developed, with round face, acne and mild hirsutism even though there was no great gain in body weight.

When the improvement appeared satisfactory after three weeks of cortisone administration, the doses were again reduced, this time tapering off gradually. They were discontinued after 41 days and a total of 7,300 mg. of cortisone acetate. The weight had increased little, but the face was distinctly rounded, the complexion became reddish, and there developed an acneiform rash.

Following the suppression of cortisone, the arthritis returned rapidly, along with great increase in the circulating eosinophil counts.

After a four week control period during which the patient remained in almost constant pain despite all the usual standard therapeutic measures, the intramuscular administration of ACTHAR-Gel was begun with doses of 20 units daily (second row, fig. 4).

The first injection was followed by a drop in the circulating eosinophil count which was much more pronounced than on any previous occasion under cortisone, and for the first time it dropped to below one third the pretreatment level. The clinical improvement was so remarkable that the injections were discontinued on the fourth day. On the fifth day there was again a severe recurrence of symptoms along with a sharp rise in the circulating eosinophil count.

The injections were then given daily for 16 consecutive days. The circulating eosinophil counts dropped remarkably again, and the improvement was most satisfactory, although not complete. Another attempt at suspending

the injection for one day was made on December 1, and again extensive involvement of various joints and an increased circulating eosinophil count ensued. The same response occurred eight days later.

From then on it was decided to continue the injections daily at the same dose of 20 units each. After a few days there was remission, and the patient was practically free from any pain or joint swelling. This remission was interrupted only on the occasion of an infection of the upper part of the respiratory tract in early January 1952 and in a milder degree for a few days about the time of the menstrual periods. In late January we began tapering off the doses of ACTHAR-Gel, which was discontinued altogether in early March, after 116 days and a total of 3,895 units had been administered. Other therapeutic measures were discontinued except for some aspirin and hot tub baths at home.

During late February measles developed and evolved uneventfully without any arthritic involvement.

The remission became almost complete and lasted until April 11 when she had a recurrence of pain in the left ankle and received 40 units of ACTHAR-Gel. There was immediate suppression of pain at this time and again on April 15 when another dose of 40 units was administered. At this writing on April 19, she was once more free from pain.

The circulating eosinophil counts remained much lower under ACTHAR-Gel than under cortisone, and the appearance of Cushing's syndrome, with rounded face and acneiform rash, persisted and gradually began to fade after therapy was discontinued.

Although it is impossible to tell how long the present remission will last, and it seems probable that she may need some form of intermittent therapy for an indefinite period of time, from a view of the chart (fig. 4) it seems evident that ACTHAR-Gel in fairly small doses was more effective in suppressing arthritic manifestations in this case than was orally administered cortisone in fairly large doses during a previous period of treatment.

It also appears evident that the circulating eosinophil count is a more sensitive indicator of therapeutic effectiveness with intramuscularly administered ACTH in this case than it is with cortisone by oral administration.

Summary

Clinical observations upon the therapeutic effects of ACTHAR-Gel by intramuscular administration not more than once daily are presented in 4 cases representing diverse pathologic conditions: status asthmaticus, pemphigus vulgaris, lupus erythematosus disseminatus and "mixed" rheumatoid arthritis.

Therapeutic response in all 4 cases was satisfactory and paralleled that usually observed when ACTH is administered by the more tedious usual fashion, intravenously or intramuscularly every six hours in similar cases.

In cases 3 and 4 a comparison between ACTHAR-Gel administered intramuscularly and orally administered cortisone seems to show that the former produces more sustained therapeutic benefits and a greater reduction in circulating eosinophil count levels.

Circulating eosinophil counts appear to parallel clinical manifestations and their drops and rises correspond respectively to shifts toward remission or recurrence of symptoms.

It may soon become more practical to administer ACTH in this long-acting form — as ACTHAR-Gel — in the routine treatment of clinical conditions in which this particular hormone is indicated rather than by the inconvenient method of giving it every six hours around the clock intramuscularly or by slow intravenous drip for eight hours each day as has been the general practice up to the last few months.

Long-acting ACTH may probably be more effective in the management of chronic conditions in which this type of therapy is indicated than orally administered cortisone. It seems possible to induce a better control of clinical manifestations with a lesser degree of side effects (Cushing's syndrome) with long-acting ACTH than with orally administered cortisone. In other words, the doses of ACTHAR-Gel required to induce remission of symptoms and to maintain significant reductions in the eosinophil counts are less likely to induce severe Cushing's syndrome than the doses of orally administered cortisone required for the same therapeutic effect.

Remissions obtained with long-acting ACTH seem more prolonged than those obtained with orally administered cortisone.

References

1. Forsham, P. H.: Present Status of ACTH and Cortisone in Therapy, M. Clin. North America 35:1229-1253 (Sept.) 1951.
2. Wolfson, W. Q.; Thompson, R. E., and Cohn, C.: Adactar and Adacthar-Gelatin: Pituitary Adrenocorticotropin Preparations with Prolonged Activity, Thirty-Second Meeting of the Association for the Study of Internal Secretions, San Francisco, June 1950.
3. Wolfson, W. Q.; Thompson, R. E.; Robinson, W. D.; Lewis, L., and Duff, I. F.: An Excellently Tolerated, Heat-Stable, Long-Acting ACTH Preparation Suitable for Prolonged and Ambulatory Treatment, Thirty-Third Meeting of the Association for the Study of Internal Secretions, Atlantic City, June 1951.
4. Randolph, T. G.: Differentiation and Enumeration of Eosinophils in Counting Chamber with Glycol Stain: Valuable Technique in Appraising ACTH Dosage, J. Lab. & Clin. Med. 34:1696-1701 (Dec.) 1949.
5. Goldzieher, J. W.: Adrenal Glands in Pemphigus Vulgaris; Report of 6 Autopsies and Review of Literature, Arch. Dermat. & Syph. 52:369-375 (Nov.-Dec.) 1945.
6. Lever, W. F., and Talbott, J. H.: Pemphigus; Further Report on Chemical Studies of Blood Serum and Treatment with Adrenocortical Extract, Dihydrotachysterol or Vitamin D, New. England J. Med. 231:41-51 (July 13) 1944.
7. Homburger, F.; Bonner, C. D., and Fishman, W. H.: Effect of Pituitary Adrenocorticotrophic Hormone (ACTH) in a Case of Pemphigus Foliaceus, J. Clin. Endocr. 10:1591-1601 (Dec.) 1950.
8. Rubin, A.: Case of Pemphigus Treated with ACTH, Arch. Dermat. & Syph. 64:196-197 (Aug.) 1951.

550 Brickell Avenue.

Discussion

DR. SIDNEY DAVIDSON, Lake Worth: I should like to thank Dr. Lamar for his most interesting paper and for his work in bringing to our attention a new weapon in the constant tug of war between the use of ACTH and cortisone in hyperergic lesions.

I had experiences similar to those of Dr. Lamar in the comparative use of cortisone and ACTH rather early in the clinical use of these two substances first made available for routine clinical use. I treated 2 cases of lupus, one superficial, the other generalized, with both cortisone and ACTH and found ACTH more effective.

The reason for ACTH being more effective than cortisone has not been clearly brought out in the literature. It may be that ACTH in its effect on the adrenal cortex does not cause production of cortisone itself. There is some evidence to show that cortisone is probably not a normal product of the adrenal cortex, but that the effective substance resulting from the use of ACTH is compound F rather than compound E. Cortisone apparently is a manufactured product, perhaps a degradation product of compound F.

The recent work that has been done on compound F has shown that its effects are similar to those of compound E, but that some of the side effects are much less obvious and severe. Only recently has a supply of compound F become available for clinical use, and early studies now show that it is capable of producing effects similar to those of compound E, or cortisone, in the prevention and reduction of symptoms in the hyperergic state, but that the side effects are not as great. Some of the work of Hollander and others on the local use of compound F, such as the injection of hydrocortone into the joint, has shown that compound F is much more effective than cortisone when applied locally, and may be milligram for milligram more effective. This may explain the fact that ACTH, which produces compound F, is more effective comparatively than cortisone.

I should like to say just one word about circulating eosinophil counts. The direct eosinophil count is subject to great variations in any one individual. These variations are diurnal and may depend on whether food has been eaten and so on. All studies have shown that although these variations are extensive, they are never more than 50 per cent. For this reason, any change of eosinophil count under 50 per cent of the original count must be discarded because of these normal variations. The original Thorn test for adrenal insufficiency, as you know, depends on the production of an eosinopenia of more than 50 per cent. In Dr. Lamar's cases in which he used a decrease in the eosinophil count as a corollary of chemical improvement you will notice that there were changes of as high as 60 to 70 per cent. I have been following the eosinophil counts in my own cases of chronic rheumatoid arthritis treated with cortisone, and despite the normal variation, it has appeared to me that the clinical course did parallel the eosinophil count. These observations, however, were in cases in which cortisone rather than ACTH was used in treatment. I believe Dr. Lamar was of the opinion that the eosinophil count was not as significant in patients treated with cortisone as it was in those treated with ACTH.

In closing, I should like to thank Dr. Lamar again for bringing to our attention a practical new weapon in the treatment of some most distressing conditions.

Dr. Lamar, concluding. Just a few words to clarify this point about the difference between ACTH and cortisone. As Dr. Davidson has just said, cortisone is a representative of a metabolic product of the secretory activity of the adrenal cortex, but we have no evidence that it is the steroid which is the most effective in the clinical improvement of our patients. ACTH, on the other hand, stimulates the adrenal cortex to produce probably several of a large group of steroids. We do not even know the physiologic action of some of them, and they may have a great deal to do in the therapeutic results that we obtain through ACTH.

Now as to the eosinophil count, the variations in the eosinophil count are tremendous, but in the same person at the same time they are usually within less than 20 per cent. In all of these cases that have been followed up for a long period of time, we have tried to make the eosinophil count, at first, at different times of the day. Then we have taken that time of the day in which a minimal degree of variation has been produced for use in our charts, and that is the same time of day in which the patients have been tested all along for comparison. The eosinophil count responded better during the administration of ACTH because at that time the therapeutic effect was also more intense. During the periods of administration with cortisone we were not obtaining the same therapeutic effectiveness probably because we were not giving enough cortisone to produce it, and because by giving more cortisone we would produce more side effects, we did not increase it. So again we say that the eosinophil counts parallel the clinical manifestations well when we use ACTH, and ACTH seems to be more effective therapeutically than cortisone, at least in the cases just reported.

Blood Transfusion Problems

John T. Stage, M.D.
J. Champneys Taylor, M.D.
and
James R. Barr, M.D.
Jacksonville

The purpose of this paper is to describe some of the possible reactions which may result from blood transfusions. The medical profession is proud of the part blood has played in the battle to make better medicine available to the patient. Knowledge of the Rh factor made clear the so-called standard crossmatch does not protect the patient against transfusion reaction. This information brought the realization that countless numbers of patients had been sensitized and was but a small warning sign of what was to follow.

A review of the literature on transfusion reactions makes one realize that the blood stream of any patient who has received blood or plasma may contain a weird assortment of antibodies, which may prove to be the cause of crossmatching difficulties and may even endanger the life of the

From the departments of Anesthesia, Obstetrics and Medicine, Riverside Hospital, Jacksonville.
Read before the Florida Society of Anesthesiologists, Fall Meeting, St. Petersburg, Sept. 30, 1951.

patient if he is given more blood. Both the physician and the patient are dependent upon transfusions. With the realization that blood is essential in modern therapy it is nevertheless well to consider each transfusion as potentially dangerous to life and to use blood only as a necessity.

Transfusion problems which may be encountered are illustrated by the 5 cases here reported, which were observed within a period of 18 months in a 50 bed hospital.

Report of Cases

Case 1.—A 32 year old woman entered the hospital complaining of vaginal bleeding. Nausea and vomiting had begun two hours prior to admission. The past history disclosed that during the preceding five years she had had dilatation and curettage on two occasions, a miscarriage and a blood transfusion. Physical examination gave essentially negative results except for vaginal bleeding, a uterus enlarged to the size of an 8 week pregnancy, and fetal membrane in the cervix.

Because of anemia a transfusion of 500 cc. of blood was ordered. After she had received 250 cc. of blood, she suffered a reaction with shock, chill and lumbar pain which necessitated stopping the transfusion. One thousand cubic centimeters of 1/6 normal molar lactate was given, and administration of intravenous fluid was continued throughout the night. The bloody appearance of 800 cc. of urine, collected by catheter, was attributed to contamination from the vaginal bleeding, which had continued. As the red blood cell count was falling, curettage was deemed necessary; hence, another transfusion was given. Following its completion she again suffered a severe reaction. Curettage stopped the uterine bleeding. During the next three weeks she showed typical signs of lower nephron nephrosis, but recovered. She became jaundiced and experienced nausea and vomiting; urea, icterus index and creatinine blood levels were elevated, and the urine persistently gave evidence of albumin, casts, red blood cells and a low specific gravity.

A study of the blood of the patient and the donors was made by Dr. Fred Allen of the Blood Grouping Laboratory, Incorporated, of Boston. Her blood was Group O Rh positive, of the subgroup Rh 1 and C negative, as was that of both her donors.

A recrossmatch of the donors' and the recipient's blood at the Jacksonville Blood Bank at the time of the reaction had disclosed no incompatibilities. Dr. Allen reported that the patient's serum contained an antibody named anti-Duffy (Anti-Fy^a), first described by Cutbush, Mollison and Parkin[1] in England. This antibody identifies a blood group antigen of a previously unknown blood group system which is completely independent of the seven well established blood group systems. The blood of approximately 65 per cent of the population is Duffy positive, and 35 per cent is negative. The indirect Coombs test will disclose which blood is likely to be compatible for the major crossmatch.

Dr. Allen examined the serum of the children of this patient. The serum of one son was Duffy negative while that of another son and a daughter was Duffy positive. He stated that future pregnancies might produce a Duffy positive fetus, which, with a sensitized Duffy negative mother, could lead to erythroblastosis fetalis. The inferences of Dr. Allen's findings were obvious. The patient is sensitized, and if she is to be given further transfusions, a Coombs crossmatch must be made on the blood of all donors. Likewise, the blood of donors for the son, who has a Duffy negative blood, should be subjected to the Coombs crossmatching test so that he in turn will not be sensitized. Dr. Allen studied the serum of the two donors whose blood had caused the reactions and, as would be expected, found it was Duffy positive.

This comparatively new factor encountered in this case, the Duffy, may be the cause of some of the formerly unexplained transfusion reactions. Any reaction from a transfusion should be investigated carefully before further blood is given to the patient. The so-called lower nephron nephrosis syndrome following transfusion reactions has been amply described in medical literature, and excellent programs have been suggested to control it.[2] It is the duty of those administering blood to acquaint themselves with this information.

Case 2.—A 26 year old primigravida was admitted to the hospital at term because of a slight elevation of blood pressure and a faint trace of albumin in a catheterized specimen of urine. The past history was noncontributory as was the family history.

Shortly after having been given 2 ounces of castor oil, the patient fell into normal labor. At one time during the labor, the blood pressure rose to 150 systolic and 100 diastolic. She received demerol and scopolamine for sedation and analgesic. When the caput became visible, the fetal heart could not be heard, although it had been heard by the obstetrician and the nurse approximately 30 minutes previously. At 4:40 a.m. she was admitted to the delivery room, and a dead female infant was delivered with controlled forceps following left mediolateral episiotomy. She was given intravenous ergotrate on presentation of the anterior shoulder and pitocin intramuscularly on presentation of the placenta. The bleeding did not appear unusual, and there were no clots. The placenta was intact. There was no obvious area of separation. She was returned to bed in good condition.

At 6 a.m. she became nauseated and vomited fresh blood in small amounts. The blood pressure began to fall. The uterus became boggy, and several large clots were expressed. The blood pressure continued to fall. Four units of plasma, 250 cc. each, were given under pressure followed by blood transfusions. Between 8:25 a.m. and 11:30 a.m. she received seven transfusions, 500 cc. each. The uterus responded to massage and ergotrate administered intramuscularly. At 11:30 a.m. she again fell into shock, and the uterus was packed under cyclopropane anesthesia. In a short time the uterus again became boggy. A hysterectomy was performed under cyclopropane anesthesia. The course under anesthesia was complicated by hypotension. During the operation 1,500 cc. of blood was given.

She awakened on the table, was returned to her room and was placed in an oxygen tent. The blood pressure was 108 systolic and 70 diastolic. The right deltoid region contained a massive hematoma at this time. She passed several large clots of blood per vagina and vomited what appeared to be digested blood. A catheterized specimen of urine contained free blood. She was given adrenal cortex and vitamin K. The course from 3:00 p.m. on was steadily downhill, and she died in frank hemorrhagic shock at 9:15 p.m.

Postmortem examination revealed hemorrhages into all organs and body cavities that were examined. The skull was not opened. Microscopic sections revealed extravasation and a virtual dissolution of capillary walls in some of the parenchymatous organs, especially the liver. The pathologist was of the opinion that the picture was classical and characteristic of acute thrombocytopenic purpura. No antemortem blood studies to substantiate this diagnosis were made, and blood drawn postmortem was not satisfactory. The pathologist put no faith in postmortem studies.

In view of the known tendency of pre-eclamptic patients and patients with abruptio placentae to

have a hemorrhagic diathesis, this case was studied closely in an effort to discover any other likely cause of death. It was presented to Dr. W. J. Dieckman, Professor of Obstetrics and Gynecology at the University of Chicago, The School of Medicine, at a round table discussion. He was of the opinion that regardless of the postmortem picture the cause of death was acute afibrinogenemia. In view of the great volume of work done on this subject in Boston, a summary of the case was sent to Dr. Duncan Reid, Professor of Obstetrics at the Harvard Medical School. He thought death probably resulted from amniotic fluid emboli to the lung with the resultant hemorrhagic consequence. Since the patient received so much fibrinogen from whole blood and plasma, Dr. John Elliot, Director of the Dade County Blood Bank in Miami, was consulted. Dr. Elliot believed the clinical picture did not represent afibrinogenemia and thought the most likely diagnosis was acute thrombocytopenic purpura.

Hemorrhage continues to be one of the commonest causes of maternal death and, in the South, it is exceeded only by toxemia. In the last 15 years, what might be termed a defect of placentation has been regarded as of greater and greater importance. Sudden death at the time of delivery associated with massive pulmonary embolism of amniotic fluid, lanugo, meconium and typical pulmonary findings has occurred often enough to exist as a clinical entity. More recently, evidence has been presented to show that there is some so-called metastasis of intrauterine content during virtually all deliveries. It has also been shown that amniotic fluid itself has what might be termed a hemorrhage factor which, in some way, operates through destruction of the circulating fibrinogen.[3-6] The Boston group has treated a number of patients with purified fibrinogen extracted from whole blood. Since fibrinogen exists in appreciable quantities in bank blood and plasma and since there is no apparent difference, it is hard to understand the value of giving the fibrinogen itself.

One further etiologic factor might be suggested. That is an abnormal functioning of the plasminogen-plasmin mechanism with fibrinolysis which is reported in the pregnant woman.

As has been stated, it is a well known clinical fact that the toxemic woman bleeds abnormally. Abruptio placentae is now being pointed out as another possible mechanism for hemorrhagic diathesis. In this type of case, the physician finds himself in a diagnostic quandary. If afibrinogenemia exists, the patient should have purified fibrinogen. If essential thrombocytopenic purpura is present, then splenectomy might save her life. If abruptio placentae or embolism caused by amniotic fluid occurs, one is confronted with a worse dilemma for both produce abnormal clotting of any available fibrin, followed by hemorrhage. It appears impossible to control clotting on the one hand and hemorrhage on the other. One might employ purified fibrinogen plus protamine sulfate or toluidine blue, both of which have been suggested for abnormal bleeding in pregnancy.[7]

It is hoped that further research will help the physician in such a case.

Case 3.—A 70 year old woman entered the hospital complaining of jaundice and anemia of several weeks duration. Diagnostic studies revealed the following: Red blood cells 1,530,000, hemoglobin 5.4 Gm., white blood cells 4,100, polymorphonuclear neutrophils 80 per cent, lymphocytes 19 per cent and monocytes 1 per cent. Anisocytosis and polychromatophilia were present. The platelet count was 52,000, the icterus index was 36, and the reaction to the Kahn test was positive in a 1:32 dilution. There was a persistent reticulocytosis, and the results of liver function tests were abnormal. The reaction to the capillary fragility test was positive. A bone marrow study revealed many forms of the erythroid elements which conformed morphologically to megaloblasts. A liver biopsy demonstrated many fat vacuoles and what was at first thought to be a large number of lymphoid round cells filling the sinusoids with focal areas of lymphocytic round cell infiltrations and perivascular lymphocytic infiltration. The liver and spleen were both palpable.

Crossmatches on the blood of the patient which was A Rh positive were attempted, but no compatible donors were found. The Coombs test was not then being done in the difficult crossmatches. The patient was given two transfusions of type O blood. One type A Rh positive blood was found to be compatible and was given, after which, type O transfusions were resumed. No untoward reactions to the transfusions were noted. Petechiae had appeared in the lower extremities, but faded in a few weeks, and there were no other signs of hemorrhage. She received nine million units of penicillin because of the positive reaction to the Kahn test.

On symptomatic treatment the anemia improved, and the icterus index became normal. She returned home with the Kahn reaction positive in a 1:8 dilution.

Eight months later she entered the hospital with weakness and purpura. There was a moderate anemia, and the platelet count was 76,000. The white blood cell count was 3,000 with an essentially normal differential count. The liver and spleen were still enlarged.

A transfusion of A Rh positive blood was given and was followed in four hours by chill, fever and bloody urine. The following day the patient felt well, and there were no signs of residual from the transfusion. Afterwards, a compatible crossmatch with neither group A nor group O with both Rh negative and Rh positive donors could be obtained. The slide method demonstrated no incompatibility, but both major and minor crossmatches agglutinated when the high protein method was used. Further studies revealed the reaction to the Coombs test to be positive both by the direct and indirect method. Tests for autoantibodies demonstrated enzyme-treated cells to be positive at 96 units at 37 degrees C. and positive at 6 units at refrigerator temperature.

The patient was given ACTH therapy, which was changed to massive doses of cortisone. During the week she received ACTH, and one compatible crossmatch with type A Rh positive blood was accomplished; however, no

transfusion was given. No successful crossmatch was obtained during the administration of cortisone therapy. During a ten day period when she again received 200 mg. of ACTH daily, no compatible crossmatches were obtained. She was discharged on symptomatic treatment.

The last hospital admission occurred three months later. By that time, there had developed dyspnea and peripheral edema in addition to the purpura. The platelet count was 108,000 and the icterus index was 16. Further peripheral blood studies and another bone marrow study revealed an abnormal number of young granulocytes. There were also many young myelocytes. No megakaryocytes were seen in the bone marrow preparation.

With the use of intravenous ACTH, a Coombs crossmatch was obtained, and a transfusion of whole blood was given without incident. Thereafter, although the intravenous ACTH was continued, only positive-negative Coombs crossmatches could be obtained. Nevertheless, several more transfusions were carefully given with no apparent reactions.

Despite the transfusions, the patient's condition became more critical, and a splenectomy with excision of four accessory spleens was performed. The immediate postoperative course was uneventful, and the platelet count increased to 252,000. In about two weeks, however, there was increased and continued destruction of the red blood cells, and the patient became greatly jaundiced. There was increased difficulty in performing compatible Coombs crossmatches; however, the blood transfusions were continued without untoward reactions. Her condition became progressively more critical, and she died on Aug. 1, 1951.

Necropsy revealed atypical granulocytic leukemic infiltrations of the bone marrow, skin and liver. The spleen, removed surgically, had previously demonstrated these findings. The microscopic diagnosis was subacute subleukemic splenomyelogenous leukemia, monocytic phase.

In this case of vague anemia with associated leukopenia, thrombocytopenia, hepatomegaly, splenomegaly and purpura, the diagnosis was difficult to establish early by the accepted methods. In addition, there appeared autoantibodies and autoimmunization of the patient's red blood cells sometimes observed with leukemia.[8,9] Hyman and Southworth[10] also reported the appearance of acquired hemolytic anemia associated with disease of the liver, such as was present here, as attested by the granulocytic infiltrations and fibrous changes in the liver. No satisfactory explanation, however, is available as to the relationship.

The development of the autoantibody presented great transfusion difficulties. In an attempt to decrease the antibody formation and reduce the hemolysis by the antibody-antigen reaction, which has been done with some success by other workers,[10-12] both ACTH and cortisone were used. The successful blood transfusions given during the last period of hospitalization were attributed to the use of intravenous ACTH. The fundamental disease, leukemia, was still present, however, and hemolysis of the patient's cells as well as the transfused cells continued. Ross and Ebaugh[9] believed that ACTH and cortisone may be life-saving in these situations, and that even splenectomy should be performed occasionally to relieve the hemolytic process although the eventual course of the leukemia would be fatal. Splenectomy in this case did not retard hemolysis. Its failure to do so, according to Dameshek and Rosenthal,[8] indicates a general production of the antibody.

It is noteworthy in this case that opposing forces were present. These forces have been described by Dameshek and Rosenthal[8] and are indicated by the megaloblastic bone marrow and the reticulocytosis. Their presence concomitantly was due to stimulation of the marrow to form new red blood cells by the increased red cell destruction. There was still a third factor present in the form of the subleukemic leukemia, which was causing the secondary thrombocytopenic purpura, although immature granulocytes in either the peripheral blood or the marrow could not be found to serve as an aid in establishing the diagnosis.

Case 4.—A 51 year old man entered the hospital in January 1951 with all the clinical signs of rheumatoid spondylitis. He was given roentgen therapy and apparently suffered a rather severe reaction. The white blood cell count fell and fluctuated from a low of 1,600 to a high of 7,500. All differential blood counts showed over 70 per cent polymorphonuclear neutrophils, predominantly old forms. No unusual cells were seen. The hemoglobin varied from 7.5 Gm. to 10 Gm., depending on transfusions, which averaged one weekly for two months following the roentgen therapy. There developed miliary follicular purpura, which faded under ACTH and transfusion therapy. Examination of the blood revealed hemoglobin 7.9 Gm., white blood cells 5,050, and platelets 36,000. Three nucleated red blood cells were seen per hundred white blood cells. A bone marrow study, at this time, disclosed a normal ratio of granulocytes to erythroid elements. The number of early erythroid elements was increased. Abnormal nuclei were seen in the later cells in this series. The megakaryocytes were bizarre in morphology and reduced in number while platelet formation was not outstanding.

The patient was given ACTH and then cortisone. Dosage of the latter was adjusted until he appeared to be getting maximum relief. Since the red blood cell count did not improve, transfusions were continued. He occasionally complained of bleeding from the gums. The purpura increased in the latter part of August. He entered the hospital for a retrial of ACTH. This was discontinued September 2. On September 6, he received a transfusion with a rather typical so-called minor reaction, that is, a chill, fever, malaise and vomiting. No hemoglobinuria or hematuria was noted. It was thought that antibodies had developed from the transfusions. A Coombs test was made on his blood. The reaction was positive. Blood for the next transfusion, despite the fact it was type O, was difficult to find at the Jacksonville Blood Bank. The blood of all donors was subjected to the Coombs test in the crossmatch. When a compatible blood was found, it was given uneventfully, except that a mild fever developed approximately three hours after completion.

On September 21, a decision was made to extract eight teeth which were badly infected despite penicillin therapy. The hemoglobin estimation was 51 per cent, the white blood cell count was 1,900, and the platelet count was 54,000. Bleeding time was three minutes and 45 seconds; clotting time was six minutes and 45 seconds. The extractions, requiring one hour and 15 minutes, were completed at 9:45 a.m., and the gums were sutured. The

patient nevertheless bled freely, losing 1,000 cc. of blood during that time. A light pack was placed on top of the incision. Then 2,000 cc. of blood and one unit of plasma were given. Two of the units of blood were Coombs crossmatched, and two were emergency O Rh positive blood with anti ab substance added. The gums continued to bleed until 1:00 p.m., and the patient was kept asleep under light nitrous oxide anesthesia so that the endotracheal tube and pack could be kept in place. One hundred milligrams of protamine sulfate was given intravenously, and 400 mg. was added to the intravenous drip. After a soft clot had formed, the patient was extubated and returned to bed at 1:30 p.m. Protamine sulfate, 100 mg. every four hours for five doses was administered intramuscularly. Aside from fever during the night and a minor hemorrhage, the course presented no further problem. It is of interest that the blood in the suction bottle had not clotted five hours after it had been removed from the patient.

In this case there developed in the blood a positive reaction to the Coombs test following multiple transfusions. A so-called minor transfusion reaction provided a clue to the condition. Despite leukopenia, anemia and a low platelet count, surgical therapy was successfully completed. The clotting mechanism returned to normal in approximately eight hours, probably as a result of blood transfusions and/or protamine sulfate therapy. It is noteworthy that antibodies developed despite treatment with ACTH and cortisone.

Case 5.—A 33 year old white woman entered the hospital complaining of purpura of one day's duration. There was no personal or family history of purpura, hemophilia or bleeding tendencies, nor had she ingested drugs or suffered from allergy which might have been the source of a secondary thrombocytopenic purpura. She had experienced menorrhagia following her last pregnancy. Nine months before entering the hospital an anemia had developed during the pregnancy, and she had been given a transfusion prior to delivery. Her blood type was A Rh negative; that of her husband was Rh positive. Two children had been born by normal delivery with no signs of erythroblastosis fetalis. The third child, delivered uneventfully, was also normal.

Her physical examination gave essentially negative results except for widespread purpura in the skin and mucous membrane. The spleen was not palpable. She was menstruating profusely.

A bone marrow study revealed hyperplasia with normal-appearing megakaryocytes. Normal-appearing platelets were being formed in the marrow from these megakaryocytes. There was a platelet count of 41,000. The clotting time by the Lee and White method was 13 minutes. The bleeding time was 41½ minutes. The prothrombin time was 17 9/10 seconds with a normal control of 16 seconds. Dilute prothrombin time disclosed more difference with the patient's prothrombin 66 seconds and the normal at 38½ seconds.

With an impending splenectomy, crossmatching was attempted. A Coombs typing of the blood was ordered with the crossmatch, and the reaction was positive. The Jacksonville Blood Bank spent considerable time in searching for a "clean" crossmatch. A Coombs crossmatch on the blood of the donors was made, since the reaction of the patient's blood to the Coombs test was positive. One blood was found that showed a completely negative Coombs crossmatch reaction. All other A Rh negative bloods in a Coombs crossmatch showed what is known as a positive-negative result, that is, many fields microscopically were not agglutinated, but occasionally an agglutinated field would appear.

An increasing anemia developed during the next week; the hemoglobin reached 50 per cent, and the red blood cells numbered 2,810,000. Because she was menstruating profusely, this factor plus the purpura was believed to be the only cause of the anemia. The blood obtained for transfusion was used, and no reaction was noted. The Miami Blood Bank was contacted and reported difficulty in the Coombs crossmatch with donors. It was found as an interesting side light at the time that the Coombs slide method identified the reaction of this patient's blood as negative while the tube method correctly identified it as positive.

The Blood Grouping Laboratory, Incorporated, of Boston was consulted and gave the following suggestion. If transfusion was mandatory, then donors' blood showing the "positive-negative" Coombs reaction could be used. It was suggested that 50 cc. of blood be given, and then a bilirubin test run on the patient's blood. If the bilirubin was not increased, implying no intravascular hemolysis, then the transfusion could be continued. This plan was followed and no reaction was noted except for a rather pronounced vascular spasm, which cleared under intravenous procaine, 0.2 per cent in saline, used in conjunction with the transfusion.

The spleen and two accessory spleens were removed. While the patient was on the operating table, the platelet count rose from 38,000 to 100,000 five minutes after removal of all splenic tissue. Forty-eight hours postoperatively, the platelet count was 234,000. She received one transfusion under anesthesia before leaving the operating room, and observation of renal function postoperatively disclosed that no apparent damage occurred from this transfusion.

In this case the blood of a patient with primary thrombocytopenic purpura reacted positively to the Coombs test. It is impossible to state whether a previous transfusion or the disease was responsible. Difficulty was experienced in locating compatible blood for this patient. If at any time one is forced to use blood which may cause a reaction, then one must give the first 50 cc. with a great deal of caution. This has been termed the biologic test when the bilirubin in the patient's blood stream is checked following this test dose.[13] Those responsible for giving blood transfusions might spare many patients reactions if they would watch for any ill effects which might be associated with administration of the first 50 cc. of blood.

Discussion

The 5 cases described might be classified as either diagnostic hemorrhagic problems, as in case 2, or transfusion problems, as in cases 1, 3, 4 and 5. These latter cases present the antibody problem. The antibodies are not discovered in a saline crossmatch. They arise from plasma and coat the red cell. Coombs serum identifies their presence and warns of the need of the Coombs crossmatch. One must realize that the Coombs test[14] is not specific, and the reactions occur in many diseases such as disseminated lupus erythematosus, thrombocyto-

penic purpura, syphilis of the liver and infectious mononucleosis. These diseases may exist in a patient who also presents a transfusion problem.

ACTH and cortisone have entered the blood transfusion field because of their ability to suppress the activity of the antibody. They may prove to be useful in the pregnant Rh sensitized woman, the multiple transfusion sensitized patient, or the patient whose disease may have caused development of autoantibodies against his own cells.[15]

Summary and Conclusions

Five cases are presented which illustrate some of the problems associated with blood transfusions. A study of these problems leads to the following conclusions:

1. Any transfusion reaction, major or minor, is important. It may lead to complete renal shutdown, hemorrhagic diathesis and sensitizing action with antibodies.[16,17]

2. When a transfusion reaction occurs, stop the transfusion, prepare for renal damage and ask for Coombs crossmatch on further transfusions.

3. Fresh blood, fresh plasma, protamine sulfate, toluidine blue, splenectomy and vitamin K help control the various types of hemorrhage, but only careful observation and understanding of the dangers help protect the patient against transfusion reactions.

Addendum

Since the presentation of this paper, there has come under our observation a case somewhat similar to the case of hemorrhagic diathesis associated with apparent premature separation which is reported herein (case 2). It is summarized as follows:

A 24 year old multipara, who had had three previous normal pregnancies and deliveries, was first seen on Dec. 12, 1951, at which time the general examination revealed an uterus enlarged to the size of a five month pregnancy, but was not otherwise remarkable except for oral sepsis. Full mouth dental roentgen study revealed that every tooth socket was seriously infected. The antepartum course was entirely normal, except for the oral condition which was actively treated by an oral surgeon, until March 26, 1952, at which time she was about 35 weeks pregnant.

During that day, she was not aware of fetal movement and in the late afternoon experienced some abdominal pain followed by a gush of bright red blood from the vagina. Following immediate hospitalization, examination revealed a tense uterus with no fetal heart tones audible. There was moderate vaginal bleeding, the blood pressure was 130 systolic and 90 diastolic, and the pulse was of good character at 84. Vaginal examination revealed a thick cervix that readily admitted an examining finger sufficiently to effect artificial rupture of membranes. The amniotic fluid was dark. Active labor supervened in a matter of an hour or two and was uncomplicated except for the vaginal bleeding, which required a transfusion during labor as replacement.

A stillborn female infant was delivered spontaneously without laceration at 11:55 p.m., and the placenta followed closely behind the baby. After the placenta was delivered, there was moderate liquid blood, and there were two clots, each about 8 cm. in diameter. Following delivery, there was no tendency for the blood expelled from the vagina to clot, and the patient was given six units of blood of 500 cc. each in rather rapid succession along with intravenous pitocin diluted in glucose solution as a slow drip. After she had received approximately 2,000 cc. of blood, ecchymotic areas, in the region of needle puncture wounds and on the lower portion of the abdomen where the uterus had been massaged, became evident. The gums and lips had started to bleed shortly before delivery and continued to bleed for several hours postpartum.

The patient showed no evidence of shock until about 4 a.m., at which time she was receiving two bottles of fresh citrated blood. Both of these units were less than 48 hours old. In view of the continued vaginal hemorrhage, she was given 5 cc. of 1 per cent protamine sulfate in the intravenous glucose solution and within a matter of a few minutes she was also given 5 cc. of 2 per cent toluidine blue. Within five minutes of this intravenous medication, fresh clots appeared at the introitus for the first time since the patient had come under observation.

The results of complete blood studies, including bleeding time, clotting time, red blood cell count, hemoglobin, white blood cell count, and smear and platelet count, were essentially normal. It is noteworthy that although the blood clotted in the test tube in about five minutes, it showed no tendency to retract and formed a soft clot.

Convalescence was uneventful following the protamine sulfate and toluidine blue medication.

References

1. Cutbush, M.; Mollison, P. L., and Parkin, D. M.: New Human Blood Group, Nature, London 165:188-189 (Feb. 4) 1950.
2. Muirhead, E. E.: Incompatible Blood Transfusions with Emphasis on Acute Renal Failure, Surg., Gynec. & Obst. 92:734-746 (June) 1951.
3. Weiner, A. E.; Reid, D. E., and Roby, C. C.: Hemostatic Activity of Amniotic Fluid, Science 110:190-191 (Aug. 19) 1949.
4. Landing, B. H.: The Pathogenesis of Amniotic-fluid Embolism. II. Uterine Factors, New England J. Med. 243: 590-596 (Oct. 19) 1950.
5. Weiner, A. E., and Reid, D. E.: The Pathogenesis of Amniotic-fluid Embolism. III. Coagulant Activity of Amniotic Fluid, New England J. Med. 243:597-598 (Oct 19) 1950.
6. Leary, O. C., Jr., and Hertig, A. T.: The Pathogenesis of Amniotic-fluid Embolism. I. Possible Placental Factors — Aberrant Squamous Cells in Placentas, New England J. Med. 243:588-590 (Oct. 19) 1950.
7. Emerson, D. M., and Allen, J. G.: Treatment of the Bleeding Patient, M. Clin. North America 35:267-278 (Jan.) 1951.
8. Dameshek, W., and Rosenthal, M. C.: The Treatment of Acquired Hemolytic Anemia with a Note on the Relationship of Periarteritis Nodosa to Hemolytic Anemia, M. Clin. North America 35:1423-1440 (Sept.) 1951.
9. Ross, J. F., and Ebaugh, F. G., Jr.: Current Trends in the Management of the Leukemias and the Malignant Lymphomas, M. Clin. North America 35:1381-1401 (Sept.) 1951.
10. Hyman, G. A., and Southworth, H.: Hemolytic Anemia Associated with Liver Disease, Am. J. M. Sc. 221:448-456 (April) 1951.
11. Best, W. R.; Limarzi, L. R., and Poncher, H. G.: Acquired Hemolytic Anemia Treated with Corticotropin, J. A. M. A. 147:827-830 (Oct. 27) 1951.
12. Wiener, A. S.: Personal communication, April 1951.
13. Oehlecker, F.: Der Sinn und Wert der biologischen Probe bei der Bluttransfusion, Chirurg. 21:261-266 (May) 1950.
14. Coombs, R. R. A.; Mourant, A. E., and Race, R. R.: New Test for Detection of Weak and "Incomplete" Rh Agglutinins, Brit. J. Exper. Path. 26:255-266 (Aug.) 1945.
15. Wiener, Alexander S.: Auto-antibody Formation and Disease, Brit. M. J. 2:163-164 (July 15) 1950.
16. Collins, J. O.; Sanger, R.; Allen, F. H., Jr., and Race, R. R.: Nine Blood-Group Antibodies in a Single Serum After Multiple Transfusions, Brit. M. J. 1:1297-1299 (June 3) 1950.
17. Malone, R. H., and Cowen, J.: Multiple Antibody Response to Repeated Transfusions, Brit. M. J. 1:1299-1300 (June 3) 1950.

2033 Riverside Avenue.

Federal Thought Control A Challenge to American Liberties and Freedom

Virgil M. Newton, Jr.*
TAMPA

It is generally customary for a dinner speaker to tell a lot of funny stories. I know a lot of stories, but I'm not going to bore you with them. Time is limited and I have a most important subject to discuss with you.

You doctors have done a magnificent job in getting out and working in politics in the last three or four years. You have learned what Plato said two thousand years ago and I quote:

> The penalty that people pay for not being interested in politics is to be governed by people worse than themselves.

But yours has been a selfish interest. You have been interested in politics only from the standpoint of socialized medicine. You have ignored the gradual infringement of personal rights guaranteed by the American Constitution on all fronts of government. You have become alarmed only when the ever-grasping politicians, with an eye to more patronage and more boondoggling, finally turned their greedy eyes to your field of medicine.

Silent on Other Moves

When President Truman last year issued an executive order giving the heads of the 2,000 federal agencies and bureaus the right to censor any news and any facts about our government, under the shallow pretense of national security, you said not a word.

When the public officials of Louisiana prosecuted five newspapermen for the sin of printing the truth about gambling in that state, not a medical society passed a resolution condemning this trampling of Constitutional rights.

You remained silent throughout the *Tampa Tribune's* fight to force the Florida State Tuberculosis Board to open its meetings to the public and conduct the people's business in the open, even though any state medical board is the first step down the road to socialized medicine.

You did not realize that if the freedom of the press and freedom of speech are curtailed or controlled in any form or fashion by the government — and there are a hundred fights going on over this principle in this country right this minute — then you will get socialized medicine, regardless of what you as individuals or as a group do about it. You did not realize that your right to practice depends on and is forever intertwined with your right to know the truth about your government.

I propose to prove to you here tonight that freedom of the press is not some high-sounding theory through which the newspaper publisher makes a lot of money. I propose to prove that it is your right and if you, as citizens, permit it to be abused in any way by the politicians, then you as doctors will find yourselves taking orders from the government, not only as to which patients you should treat, but also how you should treat them.

Methods of Control

Our federal government today employs two methods in the attempt to control the press. They are:

1. Direct and outright censorship. The best example of this is the censorship of income taxes. There is no need for me to rehash here all the scandals that have been developed in Washington behind the cloak of secrecy and which have been aired in our newspapers during the last few weeks.

2. Propaganda, which is nothing more and nothing less than attempted thought control. And it is in this field that our government has waged its campaign for socialized medicine.

Both methods are necessary to a dictator and a police state. I would like to quote to you a statement made by a brave Argentine Congressman, Mauricio L. Yadarola, who appealed in 1950 to his people to overthrow Dictator Peron. Mr. Yadarola said:

*Managing Editor, Tampa Morning Tribune.

Presented at the annual dinner, Florida Medical Association, April 29, 1952.

> And what propaganda should a state put out? In a democratic government, none; because the only propaganda is the good work of the government; but in totalitarian regimes the people must be fooled about the work of the government and the virtues of the regime, and to do this their ears must be bombarded continually until the lie is accepted as the truth.

Ideologies thrive only through propaganda. Modern government press agentry, as we know it in America today, came into its own in the American government in the dark days of the early thirties, then flowered into luxuriant bloom first in the New Deal, then in the Fair Deal. Men like Washington and Jefferson did not need press agents because they dealt in simple truths.

Today, according to the Congressional Record, the federal government is spending $100,000,000 a year for its press releases, prepared by 50,000 government press agents, and $200,000,000 a year for the printing of these releases. That is a total of $300,000,000 a year for federal propaganda.

This propaganda, put out under the guise of government news, is a violation of federal law. Section 201, title 18, of the U. S. Code, in plain legal language, forbids the use of federal funds in any manner designed to bring pressure on Congress for any legislation.

How It Works

In 1945, President Truman sent a message to Congress calling for a national health insurance program, which was nothing more than socialized medicine. Shortly afterwards, Thomas Parran, Surgeon General of the United States Public Health Service, sent a letter of instructions to all employees of that government agency. One paragraph of that letter read as follows:

> Every officer of the Public Health Service will wish to familiarize himself with the President's message and will be guided by its provisions when making any public statement likely to be interpreted as representing the official views of the Public Health Service.

Later Dr. Herman Hilleboe, an official of the Public Health Service, was called as a witness before a House of Representatives Committee investigating government propaganda and quizzed as to why the propaganda issued by his agency supported socialized medicine as embodied in the pending health insurance bill.

Dr. Hilleboe replied:

> We would naturally give emphasis to that, because that is why we are in the government. Otherwise, we should get out of the government.

This is a strange concept coming from a public servant of a so-called Democracy. Dr. Hilleboe implied that if you do not favor socialized medicine, then you have no business in the government. He further implied that it was perfectly all right for a government official to spend taxpayers' funds in pushing our republic down the road to socialism, even though Congress at no time approved any policy favoring socialized medicine or had appropriated funds for such propaganda.

It's All in the Records

The pages of the Congressional Record are crammed with documentary evidence of the 10-year propaganda effort of our federal government to foist socialized medicine upon the public, regardless of whether the public wanted it or not. This campaign to promote the national health insurance bill was sparkplugged by the Social Security Board but also was materially aided and abetted by the Public Health Service, the Children's Bureau, the Office of Education, the U. S. Employment Service and the Department of Agriculture.

Over the years, hundreds and hundreds of pamphlets, booklets and press releases were issued by these six federal agencies, all painting in wonderful colors the beauties of socialized medicine. Not one pamphlet or press release was issued pointing up the evils of state medicine as practiced by the German government under Hitler or socialized medicine as practiced in Great Britain today. One pamphlet issued by the Public Health Service even went so far as to advise its recipients:

> You can write a letter to the Readers' Column of your local newspaper, tell your editor why the readers of the paper should back the national health insurance.

Harry J. Becker, health consultant of the Children's Bureau, was asked by a Congressional investigating committee if he gave both sides of the question of compulsory health insurance.

"I don't know what you mean by both sides," replied Mr. Becker.

Oscar Ross Ewing, Federal Administrator of Social Security, is the master propagandist of a government of and by propaganda. He admitted to a Congressional investigating committee that he has no less than 65 full-time press agents on his payroll. And when Rep. Clarence Brown, of Ohio, asked him what right he had in propagandizing in favor of the President's compulsory medical insurance program, which is socialized medicine, Ewing airily replied: "It is not only my right

but my duty." All of which may explain why President Truman twice sought to elevate him to a cabinet job in charge of the nation's health, education and security.

Classic Whitewash

In March 1950, the House Buchanan Committee investigating lobbying activities asked the U. S. General Accounting Office for a report on a tour of Europe taken by Ewing and a selected staff of FSA assistants between Dec. 1, 1949 and Jan. 17, 1950. The Comptroller General, in turn, asked Ewing for a statement. That statement was a classic in whitewash. Ewing told the Comptroller General that his mission was "an official survey approved in advance by President Truman." The Comptroller General, in turn, passed along Ewing's statement to Congress with the observation, "There is no information readily available to this office which indicates the facts to be other than reported." Congress did exactly nothing and the cost of Ewing's European junket to the American taxpayers still remains a deep, dark secret.

The junket, itself, was a complete triumph for socialized medicine. From London, Dublin, Edinburgh, Stockholm, Rome and Tel Aviv, the press and radio reported thousands of glowing words from the Ewing medicine show. On his return to this country, New York newspapers quoted Ewing, "I come home with even greater confidence in President Truman's proposal for national health insurance in the United States."

The "Health Workshops"

The federal propaganda campaign for socialized medicine was built around what the bureaucrats called the "Health Work Shops." The first organization meeting to form the "Health Work Shops" was held in Washington, Nov. 2, 1945. Twelve persons attended — ten of them full-time employees of the Public Health Service, the Social Security Board and the Department of Agriculture. Subsequently, "Health Work Shops" were held in Chicago, St. Paul, Jamestown, N. D., and Denver, Col. Eighty persons attended the St. Paul "Shop," of which 17 were full-time government employees representing seven bureaus. Ninety-eight attended at Jamestown, 18 of whom were federal employees.

Rep. Forest A. Harness, of Indiana, chairman of the House Subcommittee on Publicity and Propaganda, which investigated the "Health Work Shops" had this to say about them:

> Not only are men and women paid substantial salaries in their federal positions for their full-time activities in other fields, but in many instances traveling expenses and incidental costs of these pressure-group meetings are paid out of the funds of the federal agencies.
>
> The Committee has, for example, a report from the General Accounting Office, showing that various federal agencies paid out a total of $1,950 in traveling expenses of federal employees to and from the Jamestown Health Work Shop. This conference took 18 federal officials away from their desks for a total of 126 man days.
>
> Another report from the General Accounting Office shows that the federal government paid almost $5,000 in traveling expenses of federal employees for a series of five Health Work Shop conferences and planning meetings held throughout the country before our investigation began.

Plan Was Simple

The propaganda plan of the "Health Work Shops" was simple. A dozen or more of the federal security officials, thoroughly embued with the theory of socialized medicine, would meet with several score carefully selected persons in a given area, always at taxpayer expense. Our public servants would carefully school their selected guests in the general art of conducting meetings, carrying on discussions and in persuading people that they cannot live without socialized medicine. These selected guests in turn, were urged to organize their own meetings and to spread the word in such fashion that a wave of pro-socialized medicine public opinion, even though it be false, would be generated and would sweep across the country and engulf Congress.

Literature prepared by the Social Security Board and pamphlets and booklets published by the CIO, the AFL and the Physicians' Forum, a propaganda agency for the national health insurance bill, would be mailed to the special guests at the "Shops." The Social Security Board literature bore such interesting titles as "Technic for the Organization of Citizen Groups," "Formation of Pressure Groups," and "Methods of Bringing About Group Action." Many of the CIO and other outside pamphlets were mailed from government offices at taxpayer expense. In submitting one pamphlet to the Subcommittee on Publicity and Propaganda, Counsel Bow said: "It is apparent from the attached summary, that this pamphlet and material for printing for compulsory health insurance plan, to be put out by the CIO, was prepared and edited by the Chief of Division of Coordination Studies, Social Security Board."

One Witness Reports

E. F. Engebretson, executive secretary of the North Dakota State Medical Association, was not invited to the Jamestown "Health Work Shop" but crashed it, anyway. When called as a witness before the Subcommittee on Publicity and Propaganda, he testified as follows:

> It was stated by Mr. Becker that the Government was interested in establishing such a demonstration project in North Dakota and in Arizona, which states, because of their normal below-average income, would have great need for comprehensive medical care on a federal basis.
>
> The proposition he made was utterly amazing; that is, to me, particularly in view of the fact that the last session of Congress refused even to report out of committee the health bill. He enumerated the following list on the blackboard of services which he promised would be available in North Dakota without any cost to the state whatsoever:
>
> (1) Locating children in need of medical care; (2) Diagnosis of all pregnant mothers and infants through the age of 21; (3) Treatment of pregnant mothers and all children through the age of 21; (4) Preventive service and periodic checkups; (5) Immunization; (6) Prenatal clinics; (7) Child-health clinics; (8) Hospital care maternity and child to age of 21; (9) Public health nursing; (10) Mental hygiene for children with behaviour problems; (11) Neurotics; (12) Dental care for maternity cases and all children to the age of 21.
>
> He stated that, for this part of the program, they have adequate unallocated funds in Washington; and that they could see to it that North Dakota had sufficient money to cover 100 per cent of these items, stating that the state would not be required to match the funds in any way.

Mr. Becker's Story

The Mr. Becker, to whom Engebretson referred, was Harry J. Becker, of the U. S. Children's Bureau, which is an agency under Ewing's Federal Security Administration. He was called to the witness stand before the committee right after Engebretson and quizzed by Representative Harness. After stuttering over several questions, Becker finally admitted, and I quote:

> I did state that federal funds were available for maternal and child-health purposes, and the listing of services that was read into the testimony were elements of a comprehensive program for mothers and children in any community; and I did give those to the conference; and I did say to the conference that these services could be financed from public funds. I did not suggest that federal funds were the only source of financing this demonstration. I suggested state funds and local funds, and I also suggested integrating voluntary prepayment plans with such a comprehensive over-all community program.

However, it is not my intention to convey the idea that North Dakota is the Federal Security Bureau's horizon. It's too big for that, and world rule is its apparent aim.

In 1946, one Dr. B. M. Davis, a member of the staff of the U. S. Public Health Service, which is one of Ewing's bureaus, was temporarily detached from his government job in Washington and sent to England. There he spent 18 months, devoting all his working time to the task of assisting in perfecting legislation for the labor government in England for the complete socialization of all hospital, medical and dental care in that country.

In reply to a query from me, Ewing carefully pointed out that this junket originated before he became Security Administrator. Then he said:

> The Public Health Service sent one of its commissioned officers to Great Britain early in 1947. This assignment was for the sole purpose of preparing a factual account of the British Health Service, without in any way passing judgment on the desirability or feasibility of the plan — which did not go into effect until July 1948.

This so-called "factual account," written by a man prejudiced for socialized medicine, was carried in a 40-page booklet, "Public Health Reports," Feb. 11, 1949, which was paid for by the American taxpayers, and it described minutely the operations of socialized medicine in Britain. What could be better propaganda for socialized medicine than this?

Dr. Davis, the author, is the son of Michael M. Davis, chairman of the executive committee of the Committee for the Nation's Health, which perhaps is the most conspicuous lay organization agitating for socialized medicine in the United States. And Representative Harness arose in the House and declared that "the Davis father long has been a co-worker with Messrs. Arthur J. Altmeyer, U. S. Commissioner of Social Security, and Isadore S. Falk, director of research and statistics in the Social Security Board, in the national and international agitation for socialized medicine."

England Went Whole-Hog

It is noteworthy to pause here and consider that the labor government of England is the first in all history to go whole-hog into socialized medicine, giving all its people free medical and dental care from gout to falling dandruff. Lenin proposed it for Communistic Russia but canny Stalin, with perhaps a better knowledge of human nature, hung some stipulations on communistic medicine.

A Russian worker gets 50 per cent cash value on his illness only after two years of uninterrupted work in the same industrial unit; 60 per cent, 80 per cent and 100 per cent if he works there three, six and more years. A Russian woman wins motherhood health privileges only if she has worked at least seven months in the same plant. Stalin, Molotov and the other high ranking Russian bureaucrats, however, can ail to their heart's content in luxury, including richly endower sanatoria and rest homes in the Caucasus and Crimea.

Bismark introduced socialized medicine to the modern world in 1884, but he limited it to worthy workers. Pure socialized medicine, like pure socialism, never has worked in the world, perhaps because man's nature never has changed since he first emerged from a cave. It is perhaps comforting to note that Emperor Diocletian, who by the way was the first man in written history to try out government price controls, was chased out of his Roman empire in 301 when he accumulated more recipients of state welfare than taxpayers. And that King Henry IV, of France, who first coined the "chicken in every pot" phrase, in the sixteenth century, was assassinated.

Set Sights on Japan

Our U. S. security officials tried to introduce socialized medicine in conquered Japan. The records of the "Tokyo Health Mission" are written plainly in the Congressional Record. On June 14, 1947, William H. Wandel, Chief of the Program Division, Bureau of Unemployment Security, who had been appointed chief of the Social Insurance Division of the Public Health and Welfare Section of the Supreme Command for the Allied Powers in Tokyo, wrote as follows to Director of Research Falk of the Social Security Board in Washington:

> We think that our need is for someone who is primarily not so much an economic analyst as one versed in health insurance. Health insurance is the major field of social security in Japan . . . Permanent revision requires amalgamating National Health Insurance with Health Insurance on a compulsory basis.

The "Tokyo Health Mission," composed of two men from the Public Health Service, one from the Social Security Board, and one from the Federal Housing Authority, left for Japan on Aug. 28, 1947. After a quick survey of the country, it drew up a set of recommendations calling for compulsory socialized medicine, right under the banner of General MacArthur's victorious American army. The General took one look at the recommendations and rushed them to the American Medical Association at Chicago for consideration and advice. And there the recommendations died a natural death. By that time, Congress had been alerted and the "Tokyo Health Mission" exploded into exactly nothing, even though it was a good, slick try by the Social Security Bureau.

I queried Ewing about this, too, and again he said the project was organized before his regime as Security Administrator, although I noted from the records that the junket left this country 10 days after he took office. Ewing said:

> At the request of General Douglas MacArthur, a mission was sent to Japan, under War Department auspices and at its expense, to evaluate and make recommendations to the Japanese Diet on their existing social security laws, including the Japanese national health insurance law of 1926. On July 3, 1948, General MacArthur publicly announced that he had accepted the formal report of the mission and that the group had earned the thanks of the Allied Nations for the time and assistance they so generously gave.

A Different Story

Under ordinary circumstances and on the face of it, Ewing might have gotten away with this smooth explanation. But unfortunately — or fortunately, depending on the way you look at it — there is in the Congressional Record a letter from Representative Harness, chairman of the Subcommittee on Publicity and Propaganda, to Chairman John Taber of the House Appropriations Committee. This letter, written after Representative Harness' committee had investigated most thoroughly the "Tokyo Health Mission," made the following charges:

> 1. That the health mission to Japan was composed entirely and exclusively of men long identified in the public record as advocates and proponents of socialized medicine not only in the United States but throughout the world.
> 2. That the real purpose of this mission is to lay the groundwork for a system of socialized medicine in Japan.
> 3. That the scheme for such a mission originated in the Division of Research and Statistics in the Social Security Board in Washington, and nowhere else.
> 4. That the nominal request for the mission was engineered through the General Headquarters of the Supreme Commander in Tokyo by federal employees sent from Washington for that particular purpose.
> 5. That General Douglas MacArthur does not favor — and does not approve — any plan to establish compulsory socialized medicine in Japan.
> 6. That the dispatch of this mission to Tokyo is a gross misuse of public funds.
> 7. That the real purpose of the mission was not to assist Japan in working out her basic problems in health and welfare, but to force upon that country a compulsory system of socialized medicine.

Active in Other Branches

The same processes of destroying individual liberty and private enterprise through insidious propaganda are going on in other branches of our federal government. The Department of Agriculture, for instance, has gone all out for the Brannan Plan, which is nothing less than socialized farming. The Federal Housing Authority, through propaganda, seeks always, at taxpayer expense, to expand public housing. And need I remind that all housing in Communist Russia belongs to the government. The Department of Interior, through propaganda, has sought to trod ruthlessly on the rights of individuals in its ever-expanding irrigation and reclamation projects, which are socialistic, any way you look at them. The Department of State, in its eagerness to spread our socialistic dollars around the world, hit new heights in propaganda to sell the American people on the beauties of the "something for nothing" philosophy in the Marshall Plan. Even our Department of Defense joined the propaganda parade, spending thousands of the taxpayer dollars to promote and sell universal military training to the Congress through the people. There are some who will tell you that the two essential requisites for a socialistic or police state are universal military training and socialized medicine.

You perhaps are wondering why you haven't read of all this in your newspapers. It is partly due to the curse of bureaucracy. American government has mushroomed into tremendous proportions. No one newspaper or group of newspapers could possibly cover in detail all of the 2,000 federal agencies and bureaus. Federal press agents are absolutely necessary to assemble the facts of government and to transmit those facts to the people. But unfortunately, many of our federal press agents have been too busy with propaganda to deal in facts. Now, on top of it all, President Truman, by executive order, has granted the legal right to the heads of all federal agencies to censor the facts about the people's business.

Correction is Possible

What is the answer? It was simple back in the thirties when Roosevelt first steered this Republic away from the honest road of Constitutional government. It is difficult today when Harry Truman can, with one scratch of his political pen, simultaneously embrace the CIO while he seizes an entire private industry. But it can be done. I need only to point to the gallant comeback of the South from the ashes of the conqueror's carpetbag government to a position where today it is sounding a clarion call to the rest of the nation to return to the principles of the American Constitution, the greatest document of free government ever devised by man. It can be done, but it will require all of the intelligence, earnest effort, and absolute unselfishness on the part of every patriotic citizen.

I conclude by quoting to you the defiant message that Henry W. Grady, the famed editor of the *Atlanta Constitution,* shouted to the North as he stood in the ashes of the conquered South. Mr. Grady said:

> If there is any human force that cannot be withstood, it is the power of banded intelligence and responsibility of a free community. Against it, numbers and corruption cannot prevail. It cannot be forbidden in the law or divorced in force. It is the inalienable right of every free community — and the just and righteous safeguard against an ignorant or corrupt suffrage. It is on this, sir, that we rely in the South.

The Scientific Department of The Journal

Reflects the Experience of You and Your Colleagues

ABSTRACTS OF MEDICAL ARTICLES

Tick Paralysis, Report of a Case in Florida. By Robert M. Alexander, M.D. J. A. M. A. 149:931-932 (July 5) 1952.

A fatal case of tick paralysis, occurring in a white man aged 24, admitted to the Veterans Administration Hospital at Lake City last April, is reported. A brief history of this disease and a general description of the syndrome are presented. There is also a typical description of such a case in a young female child, since the vector, which may be the wood tick Dermacentor andersoni Stiles in the Western United States or the dog tick Dermacentor variabilis Say in the Eastern United States, often lodges on young female children, where its concealment in the longer hair allows sufficient time for the syndrome to develop.

The tick usually feeds from nine to 16 days and apparently releases a toxin that is at its height of potency around the fifth or sixth day. The toxin, which is neurotrophic, acts on the spinal cord and bulbar nuclei.

It is emphasized that the only treatment is the early removal of the offending ticks.

Retinal Detachment, Spontaneous Reattachment Following Aureomycin Therapy. By S. B. Forbes, M.D. Am. J. Ophth. 34:1597-1599 (Nov.) 1951.

In view of present interest in the therapeutic action of the antibiotics in many ocular conditions, a case of retinal detachment is reported in which spontaneous reattachment followed aureomycin therapy. In a man aged 31, detachment of the lower portion of the retina occurred, with multiple holes in the periphery and considerable cystic retinitis in the surrounding area. The retina was successfully reattached by means of diathermic surgery. There were positive reactions to intradermal Mantoux and brucellosis tests. Serologic tests for brucellosis gave mildly positive results.

Some three months following the operative procedure, the upper portion of the retina detached completely and suddenly, and a considerable number of vitreous opacities were present. There followed spontaneous reattachment two weeks later with the patient receiving only aureomycin therapy by mouth in the usual manner, 250 mg. five times daily. This eye now has practically as much central vision as the other eye.

Progress in the Surgical Treatment of Bilateral Laryngeal Paralysis. By Thomas M. Edwards, M.D. Ann. Otol., Rhin. & Laryng. 61:159-179 (March) 1952.

Bilateral recurrent laryngeal paralysis, clinically known as bilateral abductor paralysis of the larynx, is discussed with regard to incidence, etiology, symptoms and treatment in this successful candidate's thesis presented to the American Laryngological, Rhinological & Otological Society. It is pointed out that the commonest cause of this distressing condition is trauma resulting from thyroidectomy.

The evolution of surgical therapy is delineated in some detail from permanent tracheotomy through cordotomy, cordectomy, ventriculocordectomy and anastomosis of the recurrent nerves to the constructive extralaryngeal procedures of the forties, which resulted in a decade of progress and brought about a renaissance of interest in the correction of this affliction. The King procedure and the Kelly procedure are described and compared. Various modifications of these well known procedures are also reviewed, notably those of Woodman and Barrett.

The new Thornell intralaryngeal approach, based on the use of the Lynch suspension laryngoscope and consisting of complete intralaryngeal arytenoidectomy with lateral fixation of the corresponding vocal cord, is carefully described, together with modifications of this procedure advocated by von Leden and Brown. Two cases are reported in which the Thornell operation with the Brown modification was employed with gratifying results.

The intralaryngeal approach is recommended for its simplicity, although as yet it is not possible to have the best airway with the best voice. While the eventual method of choice is regarded as problematic, it is suggested that selection may be on an anatomic basis. For patients with a large larynx the intralaryngeal procedure may prove most suitable, and for those with a small larynx the extralaryngeal procedure may be preferable.

It is urged that every effort be made to reduce the incidence of bilateral laryngeal paralysis as a sequela of thyroidectomy by observing the precautions mentioned.

FLORIDA MEDICAL ASSOCIATION

OFFICERS AND COMMITTEES

OFFICERS

ROBERT B. MCIVER, M.D., President.....*Jacksonville*
FREDERICK K. HERPEL, M.D., Pres.-elect..*West Palm Beach*
FRANCIS H. LANGLEY, M.D., 1st Vice Pres...*St. Petersburg*
ERASMUS B. HARDEE, M.D., 2nd Vice Pres.....*Vero Beach*
H. QUILLIAN JONES, M.D., 3rd Vice Pres.....*Fort Myers*
SAMUEL M. DAY, M.D., Sec'y-Treas.....*Jacksonville*
SHALER RICHARDSON, M.D., Editor.....*Jacksonville*

MANAGING DIRECTOR

STEWART G. THOMPSON, D.P.H.....*Jacksonville*
ERNEST R. GIBSON, Assistant.....*Jacksonville*

BOARD OF GOVERNORS*

ROBERT B. MCIVER, M.D., Chm...(Ex Officio).*Jacksonville*
JAMES L. BORLAND, M.D...AL-53.....*Jacksonville*
DUNCAN T. MCEWAN, M.D...B-53.....*Orlando*
JAMES H. POUND, M.D...A-54.....*Tallahassee*
NORVAL M. MARR, M.D...C-55.....*St. Petersburg*
JOHN D. MILTON, M.D...D-56.....*Miami*
HERBERT E. WHITE, M.D...PP-53.....*St. Augustine*
DAVID R. MURPHEY, JR., M.D...PP-54.....*Tampa*
FREDERICK K. HERPEL, M.D. (Ex Officio).*W. Palm Beach*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*
HERBERT L. BRYANS, M.D...S.B.H.-53.....*Pensacola*
STEWART G. THOMPSON, D.P.H. (Advisory)...*Jacksonville*

*SUB-COMMITTEES

1. Veterans Care
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
GEORGE M. STUBBS, M.D.....*Jacksonville*
DOUGLAS D. MARTIN, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

2. Advisory to National Foundation Infantile Paralysis
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
H. PHILLIP HAMPTON, M.D.....*Tampa*
ROBERT P. KEISER, M.D.....*Coral Gables*
RICHARD G. SKINNER, JR., M.D.....*Jacksonville*

3. Review of Fee Schedules
JOHN D. MILTON, M.D., Chm.....*Miami*
WOODROW B. ESTES, M.D.,.....*St. Petersburg*
FREDERICK H. BOWEN, M.D.....*Jacksonville*
ODIS G. KENDRICK, JR., M.D.....*Tallahassee*
JAMES B. GLANTON, M.D.....*Orlando*
FLOYD K. HURT, M.D.....*Jacksonville*
HERSCHEL G. COLE, M.D.....*Tampa*
A. FRANKLIN HARRISON, M.D.....*Madison*
JACK O. W. RASH, M.D.....*Miami*
KENNETH S. WHITMER, M.D.....*Miami*
ADELBERT F. SCHIRMER, M.D.....*Orlando*

4. Blue Shield
LEIGH F. ROBINSON, M.D., Chm.....*Fort Lauderdale*

SCIENTIFIC WORK

JAMES N. PATTERSON, M.D., Chm...AL-53.....*Tampa*
CAROL C. WEBB, M.D...A-53.....*Pensacola*
FREDERICK K. HERPEL, M.D...D-54.....*West Palm Beach*
JERE W. ANNIS, M.D...C-55.....*Lakeland*
RICHARD C. CUMMING, M.D...B-56.....*Ocala*

LEGISLATION AND PUBLIC POLICY

H. PHILLIP HAMPTON, M.D., Chm...B-53.....*Tampa*
WILLIAM M. ROWLETT, M.D...AL-53.....*Tampa*
DANIEL A. MCKINNON, M.D...A-53.....*Marianna*
ANGUS D. GRACE, M.D...C-55.....*Fort Myers*
DONALD W. SMITH, M.D...D-56.....*Miami*
ROBERT B. MCIVER, M.D. (Ex Officio).....*Jacksonville*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*

MEDICAL EDUCATION AND HOSPITALS*

JACK Q. CLEVELAND, M.D., Chm...AL-53.....*Coral Gables*
JULIUS C. DAVIS, M.D...A-53.....*Quincy*
ELBERT MCLAURY, M.D...D-54.....*Hollywood*
S. CARNES HARVARD, M.D...C-55.....*Brooksville*
BENJAMIN F. DICKENS, M.D...B-56.....*Fernandina*

*SPECIAL ASSIGNMENT

1. Urge Gifts to American Medical Education Foundation

PUBLIC RELATIONS*

EUGENE B. MAXWELL, M.D., Chm...AL-53.....*Tampa*
LEIGH F. ROBINSON, M.D...D-53.....*Fort Lauderdale*
HOWARD V. WEEMS, SR., M.D...C-54.....*Sebring*
EUGENE G. PEEK, JR., M.D...B-55.....*Ocala*
HENRY L. SMITH, JR., M.D...A-56.....*Tallahassee*

*SPECIAL ASSIGNMENTS

1. Rural Educational Program
2. State Education Campaign

NECROLOGY

ALVIN L. STEBBINS, M.D., Chm...A-56.....*Pensacola*
HUGH WEST, M.D...AL-53.....*DeLand*
JOSEPH HALTON, M.D...C-53.....*Sarasota*
WALLACE H. MITCHELL, M.D...D-54.....*Key West*
JOSEPH J. LOWENTHAL, M.D...B-55.....*Jacksonville*

MEDICAL POSTGRADUATE COURSE

TURNER Z. CASON, M.D., Chm...B-55.....*Jacksonville*
ARTHUR J. BUTT, M.D...AL-53.....*Pensacola*
FRANZ H. STEWART, M.D...D-53.....*Miami*
J. BROWN FARRIOR, M.D...C-54.....*Tampa*
FRANCIS T. HOLLAND, M.D...A-56.....*Tallahassee*

CANCER CONTROL

FRAZIER J. PAYTON, M.D., Chm...D-54.....*Miami*
MILTON C. MALONEY, M.D...AL-53.....*Jacksonville*
ROBERT L. TOLLE, M.D...B-53.....*Orlando*
GEORGE W. MORSE, M.D...A-55.....*Pensacola*
WESLEY W. WILSON, M.D...C-56.....*Tampa*

MEDICAL ECONOMICS

REUBEN B. CHRISMAN, JR., M.D., Chm...AL-53....*Miami*
JOHN E. MAINES, JR., M.D...B-53.....*Gainesville*
HARRISON A. WALKER, M.D...D-54.....*Miami*
WILLIAM H. WALTERS, JR., M.D...C-55.....*Lacoochee*
WILLIAM C. ROBERTS, M.D...A-56.....*Panama City*

VENEREAL DISEASE CONTROL

MELVIN M. SIMMONS, M.D., Chm...C-55.....*Sarasota*
JOHN R. BROWNING, M.D...AL-53.....*Jacksonville*
JOHN C. MCSWEEN, JR., M.D...A-53.....*Pensacola*
WILEY M. SAMS, M.D...D-54.....*Miami*
DAVID W. GODDARD, M.D...B-56.....*Daytona Beach*

TUBERCULOSIS AND PUBLIC HEALTH*

RALPH S. SAPPENFIELD, M.D., Chm...AL-53.....*Miami*
PHILLIP W. HORN, M.D...B-53.....*Jacksonville*
ERASMUS B. HARDEE, M.D...D-54.....*Vero Beach*
LOUIS J. GARCIA, M.D...C-55.....*Tampa*
HARRY S. HOWELL, M.D...A-56.....*Lake City*

*SPECIAL ASSIGNMENT

1. Diabetes Control

STATE CONTROLLED MEDICAL INSTITUTIONS

William D. Rogers, M.D., Chm...A-56....*Chattahoochee*
James L. Anderson, M.D...AL-53.....*Miami*
Bailey B. Sory, Jr., M.D...D-53.....*Palm Beach*
James G. Lyerly, M.D...B-54.....*Jacksonville*
Samuel G. Hibbs, M.D...C-55.....*Tampa*

MATERNAL WELFARE

E. Frank McCall, M.D., Chm...B-56.....*Jacksonville*
T. Bert Fletcher, Jr., M.D...AL-53.....*Tallahassee*
Lowrie W. Blake, M.D...C-53.....*Bradenton*
John N. Sims, Sr., M.D...A-54.....*Live Oak*
Ralph W. Jack, M.D...D-55.....*Miami*

CHILD HEALTH

Luther W. Holloway, M.D., Chm...B-53....*Jacksonville*
James R. Boulware, Jr., M.D...AL-53.....*Lakeland*
Warren W. Quillian, M.D...D-54.....*Coral Gables*
Daniel F. H. Murphey, M.D...C-55.....*St. Petersburg*
Courtland D. Whitaker, M.D...A-56.....*Marianna*

CONSERVATION OF VISION

Ralph N. Greene, Jr., M.D., Chm...AL-53..*Jacksonville*
William Y. Sayad, M.D...D-53.....*West Palm Beach*
Sherman B. Forbes, M.D...C-54.....*Tampa*
G. Tayloe Gwathmey, M.D...B-55.....*Orlando*
Mozart A. Lischkoff, M.D...A-56.....*Pensacola*

ADVISORY TO WOMAN'S AUXILIARY

C. Robert DeArmas, M.D., Chm...B-55....*Daytona Beach*
Benjamin H. Sullivan, M.D...AL-53.....*St. Petersburg*
Edward F. Shaver, M.D...C-53.....*Tampa*
James L. Anderson, M.D...D-54.....*Miami*
Taylor W. Griffin, M.D...A-56.....*Quincy*

REPRESENTATIVES TO INDUSTRIAL COUNCIL*

Charles R. Burbacher, M.D., Chm...D-55..*Coral Gables*
Fred H. Albee, Jr., M.D...AL-53.....*Orlando*
G. Frederick Oetjen, M.D...B-53.....*Jacksonville*
Chas. L. Farrington, M.D...C-54.....*St. Petersburg*
Lee Sharp, M.D...A-56.....*Pensacola*

*SPECIAL ASSIGNMENT

1. *Industrial Health*

COUNCILOR DISTRICTS AND COUNCIL

Eugene G. Peek, Jr., M.D., Chm...AL-53.....*Ocala*
First—Francis M. Watson, M.D...1-54.....*Marianna*
Second—Benjamin A. Wilkinson, M.D...2-53.*Tallahassee*
Third—William C. Thomas, Jr., M.D...3-54..*Gainesville*
Fourth—Eugene L. Jewett, M.D...4-53.....*Orlando*
Fifth—Hugh G. Reaves, M.D...5-53.....*Sarasota*
Sixth—Emmett E. Martin, M.D...6-54.....*Haines City*
Seventh—Erasmus B. Hardee, M.D...7-54....*Vero Beach*
Eighth—Donald W. Smith, M.D...8-53.....*Miami*

GRIEVANCE COMMITTEE

Walter C. Payne, M.D., Chm.....*Pensacola*
David R. Murphey, Jr., M.D.....*Tampa*
Herbert E. White, M.D.....*St. Augustine*
Joseph S. Stewart, M.D.....*Miami*
William C. Thomas, Sr., M.D.....*Gainesville*

ADVISORY TO SELECTIVE SERVICE FOR PHYSICIANS AND ALLIED SPECIALISTS

J. Rocher Chappell, M.D., Chm.....*Orlando*
Thomas H. Bates, M.D...“A”.....*Lake City*
Frank L. Fort, M.D...“B”.....*Jacksonville*
Alvin L. Mills, M.D...“C”.....*St. Petersburg*
John D. Milton, M.D...“D”.....*Miami*

EMERGENCY MEDICAL SERVICE

James V. Freeman, M.D., Chm.....*Jacksonville*
Merritt R. Clements, M.D...“A”.....*Tallahassee*
Vernon A. Lockwood, M.D...“B”.....*St. Augustine*
Herschel G. Cole, M.D...“C”.....*Tampa*
Frederick K. Herpel, M.D...“D”.....*West Palm Beach*

A.M.A. HOUSE OF DELEGATES

Homer L. Pearson, Jr., M.D., Delegate.....*Miami*
Frank D. Gray, M.D., Alternate.....*Orlando*
(Terms expire Dec. 31, 1952)

Louis M. Orr, II, M.D., Delegate.....*Orlando*
Joshua C. Dickinson, M.D., Alternate.....*Tampa*
(Terms expire Dec. 31, 1953)

Herbert L. Bryans, M.D., Delegate.....*Pensacola*
Thomas H. Bates, M. D., Alternate.....*Lake City*
(Terms expire Dec. 31, 1955)

BOARD OF PAST PRESIDENTS

William E. Ross, M.D., 1919.....*Jacksonville*
H. Marshall Taylor, M.D., 1923.....*Jacksonville*
John C. Vinson, M.D., 1924.....*Fort Myers*
John S. McEwan, M.D., 1925.....*Orlando*
H. Mason Smith, M.D., 1926.....*Tampa*
John A. Simmons, M.D., 1927.....*Arcadia*
Frederick J. Waas, M.D., 1928.....*Jacksonville*
Julius C. Davis, M.D., 1930.....*Quincy*
William M. Rowlett, M.D., Chm., 1933.....*Tampa*
Homer L. Pearson, Jr., M.D., 1934.....*Miami*
Herbert L. Bryans, M.D., 1935.....*Pensacola*
Orion O. Feaster, M.D., 1936.....*Renton, Wash.*
Edward Jelks, M.D., 1937.....*Jacksonville*
W. Henry Spiers, M.D., 1938.....*Orlando*
Leigh F. Robinson, M.D., 1939.....*Fort Lauderdale*
Walter C. Jones, M.D., 1941.....*Miami*
Eugene G. Peek, Sr., M.D., 1943.....*Ocala*
John R. Boling, M.D., 1944, 1945.....*Tampa*
Shaler Richardson, M.D., 1946.....*Jacksonville*
William C. Thomas, Sr., M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne, M.D., 1949.....*Pensacola*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey, Jr., M.D., Sec'y., 1951.....*Tampa*

From Our President

Medical Education Crusade

Fides sanctissimum humani pectoris bonum est.

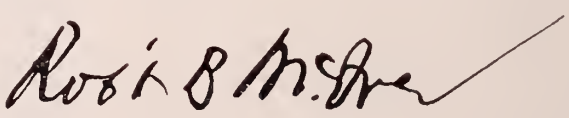
The nostalgic pleasure of attending a class reunion, whether after 10 years or 50, attests one's loyalty to his alma mater. To many physicians fortunate enough to mingle again with associates of college days amid familiar campus scenes at recent June commencements, the experience brought a resurgence of school loyalty and a vivid reminder of the vital cause of medical education throughout the land.

Every physician now in practice realizes that his medical education was obtained only at a cost far exceeding the tuition which he paid. He became the recipient of a free gift of thousands of dollars, representing the difference between the tuition and the actual cost. Someone, somehow, had to pay the costs, but today inflation and the tax situation have shrunk endowment dollars beyond the point of absorbing this deficit. The medical profession, therefore, has now embarked upon a great venture in medical philanthropy to repay this gift from the past so that present and future physicians of the nation can, in turn, obtain their education without the possibility of government control.

The movement of the American Medical Education Foundation to that end, started last year, has steadily gained momentum, and by mid 1952 the number of individual physicians making contributions exceeded by 39 per cent the total number of individual contributors for the entire year 1951. The goal for this year is $2,000,000.

Perennially in September, as in June, the nation is particularly school-minded. There is no better time than right now, when the youth of the land are returning to the halls of learning, for physicians to give tangible expression of their loyalty to the institutions which made possible for them the practice of their profession. Surely every physician who has not already done so will wish to participate in this laudable undertaking by promptly making a generous contribution to the Foundation. If it is directed to his alma mater, that school will receive the full amount of the contribution plus its full share of unearmarked funds. The Florida Medical Association's Committee on Medical Education and Hospitals and the corresponding committee in each component county medical society are counting on the cooperation of every member in this project.

"Loyalty is the holiest good in the human heart," wrote Seneca—a message as applicable today as in the long ago. Loyalty to this great constructive program, with deeds as well as words, is also loyalty to the basic concepts and tenets of democracy.



The Journal of the
Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. BOX 1018 JACKSONVILLE, FLORIDA

Editor
Shaler Richardson, M.D.

Assistant Editors
Webster Merritt, M.D.
Franz H. Stewart, M.D.

Associate Editors

Louis M. Orr, II, M.D. ..... Orlando
Joseph J. Lawenthal, M.D. ..... Jacksanville
Jere W. Annis, M.D. ..... Lakeland
Herschel G. Cale, M.D. ..... Tampa
Wilson T. Sawder, M.D. ..... Jacksanville
Carlos P. Lamar, M.D. ..... Miami
Walter C. Payne, M.D. ..... Pensacala

Managing Editor
Stewart G. Thompson, D.P.H.
Ernest R. Gibson, Asst.

Committee on Publication

Shaler Richardson, M.D., Chairman ..... Jacksanville
Chas. J. Callins, M.D. ..... Orlanda
James N. Patterson, M.D. ..... Tampa

Abstract Department

Kenneth A. Marris, M.D., Chairman ..... Jacksonville
Walter C. Janes, M.D. ..... Miami

The New World

Myths, Martyrs and Medicine Men
Legend, Fiction and Fact

During the early sixteenth century, nearly 440 years ago, Juan Ponce de Leon landed on the east coast of North America, took possession in the name of the King of Spain and named it La Florida because the season was that of the flowery festival or Feast of Flowers. The actual date was not Easter Sunday, as widely supposed, but Saturday, April 2, 1513. The coast at that time was not flowery, although many historians have labored so to describe it.

The exact spot where Ponce De Leon landed probably never will be known. The only historical record of the voyage available today was written by Herrera nearly 80 years later. Various interpretations of the record have placed the site of the first landing between the mouth of the St. Johns River and Miami, a distance of some 350 miles. The most scholarly studies and most careful interpretation of source material indicate that the location was probably between Jacksonville Beach and St. Augustine, perhaps not far from the present site of Ponte Vedra Beach.

Juan Ponce apparently was not interested in flowers nor even a fountain of youth. He wanted gold and slaves, but he found neither. He named the land from the church calendar and soon set sail. The legend of the Fountain of Youth is the first and best known of all the legends in the New World. Apparently Ponce was convinced, as were all other companions of Columbus and discoverers of that day, that he ruled over islands near Asia, known as the land of wonder and marvels.

The particulars of Juan Ponce's voyages are to be found in the histories of Herrera, Gomara and Peter Martyr. They are regrettably scanty, but their very scantiness has allowed to remain undisturbed the romantic background and shadowing of Ponce's aims and purposes described by poet and romanticist.

Ponce de Leon must have been familiar with the legends of rivers or springs "of running water of such marvellous virtue, that the water thereof being drunk with some diet, makes old men young again." The historian Herrera, when he told Juan Ponce's story many years later, found the legend in Fontaneda's manuscript of 1575, made notes in the margin in his own handwriting showing how he intended to use it, and then pinned the fountain legend on Ponce long after his death — a legend which arose not from the tradition of the natives in the West Indies but which crossed the ocean with Columbus and his companions.

Actually, the written history of Florida probably begins soon after the voyage of Columbus, before the close of the fifteenth century. The Italian-born English navigator, John Cabot, seems

HIRRIHIGUA'S DAUGHTER

This print by Lasso de la Vega (Leiden, 1731) portrays the romantic incident of 1528 in which the daughter of the Indian chief Hirrihigua pleads for the life of Juan Ortiz, an 18 year old captive who was a follower of Narvaez. Ortiz lived to take a place in history as guide and interpreter for Hernando de Soto. In the background is depicted the artist's conception of a Timucuan village on or near Tampa Bay.

to have sailed from Europe in 1497, followed the coast of North America south to Florida and returned to Europe the following year. At about the same time, the Italian-born Spanish navigator, Amerigo Vespucci, made the first of a series of four secret voyages to the New World which have remained shrouded in mystery. Apparently these voyages were involved with a Portuguese expedition, traces of which can be found on a map prepared in Lisbon by an unidentified person named Alberto Cantino. This map, prepared prior to 1502, depicts land which probably represents the peninsula of Florida. It may be that these expeditions were purposely kept secret because the land explored had been ceded to Spain by Pope Alexander VI in 1493.

In 1503, a general license to search for Caribs to be sold as slaves was granted an official of Hispaniola. The fact that the Indians of Florida greeted Ponce de Leon with hostility supports the belief that slave traders had landed prior to his arrival and had made raids upon the natives.

Thus it was when Ponce, on his second and final voyage in February 1521, set foot on Florida again, hoping to claim and settle the land he had discovered. The Indians attacked ferociously, killing some Spaniards and wounding others. The Adelantado, Ponce himself, was wounded by an Indian arrow which struck deeply into his thigh through a joint in his armor. Returning with his men to Havana, he died there several days later. On his sepulcher in Porto Rico, where his body was sent for burial, this epitaph was inscribed:

Mole sub hoc fortis requiescunt osa LEONIS
Qui vici factis nomina magna suis.

Variously translated, it reads:

Here rests THE LION brave whose deeds of fame
Surpassed in might the valor of his name.

There is legend and much fiction but probably little truth to support tales about the white, long-haired Indians found by Ayllon on his voyage in 1520 to "eastern Florida," territory lying well to the north of Florida today. Barcia states that the voyagers found a cacique and his consort there who were artifically produced giants. Reportedly, the Indians of that region applied poultices and herbs to soften the bones of the unweaned child destined to reign. They then stretched his bones

BUILDING OF FORT CAROLINE

This spirited portrayal of the building of Fort Caroline, by Montanus of Amsterdam in 1671, is reminiscent of the early days of an ill-fated attempt of the Huguenots to establish a settlement in Florida at St. Johns Bluff on the south side of the St. Johns River near its mouth. There "Fort Caroline was a direct menace to the rich Spanish Fleets, offering a safe harbor to cruisers." It is shown on Le Moyne's Florida Map as Carolina on "River May."

until the child was almost dead. The wet nurse, who had been nourished with sustaining foods, gave breast to the child in a protected place until the masters returned to stretch the bones of the child again and treat the nurse as before. Thus the little prince was fashioned to become a giant in accordance with "the Indians' art and practice." From hearsay, others reported of the same Indians that the child destined to reign was given foods so efficacious and herbs so rare that he was "nurtured" to great height. In addition to these tales of the giant kings, Ayllon brought back to Cuba reports of vast wealth in gold and pearls abounding in the land he had explored, probably along the Carolina coast.

Panfilo de Narvaez, a Spanish captain who had witnessed the conquest of Mexico, was stirred by the reports of Ayllon. Given the right to discover, conquer and people all the land from the Mexican border to the end, or cape, of Florida, Narvaez set out with a fleet of five ships and after many misfortunes cast anchor on April 16, 1528, "off the mouth of an inlet which perhaps was Johns Pass, just north of Tampa Bay." With 300 men he began a march inland after three ships had been dispatched along the coast to locate the Mexican border Rio de las Palmas, thought to be nearby. Because of mishaps and repeated misfortunes, only four members of the entire expedition finally reached their own people in Mexico. To one of

"HOW THEY TREAT THEIR SICK"

This scene shows how the Timucua Indians cared for their sick. Upon a bench built long enough and wide enough for the purpose, they laid the sick person, either on his back or on his stomach depending upon the nature of his illness. Then they cut his forehead with a sharp shell and sucked the blood from the wound, spitting it into an earthen jar or a gourd. Nursing or pregnant women drank this blood, especially if it was that of a strong young man, in the belief that it would make their children strong.

The sick man placed face downward inhaled smoke from a fire of hot coals on which seeds had been thrown in order to expel the poison and cure the disease.

After carefully drying the leaves of a plant, which "the Brazilians call petum and the Spaniards tapaco," they smoked them in a pipe, inhaling deeply and exhaling through the mouth and the nose, as a remedy for infections. They also had several natural remedies for venereal disease.

TIMUCUAN CHIEF OUTINA CONSULTS A SORCERER

Upon reaching the enemy's territory, Chief Outina halted his forces to consult a sorcerer-physician-priest, reputedly more than 120 years old. In the midst of the warriors, the sorcerer laid Outina's shield on the ground, drew a circle around it and inscribed various signs upon it. Then kneeling on it, he whispered unintelligible words and gesticulated as if engaged in animated conversation. Soon his features became so distorted that he looked scarcely human; he twisted his limbs, snapping bones out of place, and engaged in other contortions. Suddenly becoming calm, he stepped out of the circle, saluted the chief and revealed to him the number of the enemy and the place of battle.

those four, Cabeza de Vaca, we owe our knowledge of that ill-fated mission.

When Narvaez did not return, his wife sent out from Havana an expedition of some 25 or 30 Spaniards to search for him. Sailing along the coast, they recognized the bay and finally the beach where Narvaez had gone ashore. There sticking in the sand of the beach they saw a cane with what appeared to be a letter in its split top. On board the ship there was a handsome young man named Juan Ortiz, who was eager to go ashore and get the letter, but only one other man would go with him for most of them were afraid of the hostile Indians.

After landing, both were seized by the natives, and upon attempting to escape, Ortiz' companion was killed immediately. Ortiz was handled roughly and then taken to a square area cut out of the brush where under a thatched roof a group of men sat on logs around their chief, talking quietly. Curious women and children, having first screamed at him in a burst of hostility, now were massed at the entrance to the square calmly watching. After leaving him tied overnight, the Indians led their captive to a spot where low posts were set in old ashes, stripped him of his clothing, bound him with thongs and stretched him over a sort of grid just as they would have stretched a large split fish for baking. As the fire began to crackle beneath him, Ortiz felt the pain of his burns and cried out in protest against this ghastly torture.

Suddenly, as if in answer to his plea, the Indians began scattering the flaming sticks, cut the thongs which bound him and led him to face their chief again. Vaguely, it is reported, Ortiz saw a comely young woman apparently pleading with the chief, King Hirrihigua. With a nod of his head, the chief ordered him taken away. Agonized by pain as a result of his burns, Ortiz began to realize that because of the earnest pleas of the chief's daughter in his behalf, he was not to die. Later he learned that the princess and other women had thought him too young and good-looking to be killed, and had persuaded the chief that his prestige would be increased by owning a white captive.

The princess ministered to young Ortiz, had salve put on his burned back and cared for his "hurts." Thus, King Hirrihigua's daughter, so far as is recorded, became the first nurse in territory which is now the United States. Not long afterward, however, the King, remembering how his mother had been cruelly treated by Narvaez, repented his clemency and ordered that Ortiz must die. The princess secretly informed Ortiz, led him from the camp and directed him to the tribe of her "affianced lover," Chief Mucoso. There he was protected despite the threats and demands of Hirrihigua and there he was found by De Soto when he landed on the west coast of Florida more than ten years later. Ortiz had virtually become an Indian in his ways, knowledge and talk. Consequently, he served as an invaluable guide and interpreter for De Soto and his men.

This dramatic story was first told by the Portuguese gentleman from the town of Elvas who learned of it from Juan Ortiz himself and included it in the clear, well known narrative of the De Soto expedition, published in Portugal in 1557, which made him famous.

The romantic rescue of Captain John Smith by the Indian princess Pocahontas is curiously parallel to this original account of a white captive's rescue by a pretty Indian maiden. Historians have wondered and still wonder why, if the Pocahontas story is true, Captain Smith did not mention it in his first version of his experiences with the Indians of Virginia in 1608. Could it be that Captain Smith's reason for waiting until 1616 to tell the Pocahontas story was that he concocted it after he read of the adventures of Juan Ortiz?

It must be admitted that the Spaniards acted unwisely and were too often cruel and unjust in their contacts and dealings with the Indians of the New World. The fierce reaction of the natives to this treatment can well be understood. On the other hand, the more kindly and friendly attitude of the French Huguenots toward native Floridians later in the century was returned by the Indians and seems to have made it possible for the white man to learn more about them and to preserve this valuable information for posterity.

In 1562, Jean Ribaut, "a man in trueth expert in sea causes," after casting anchor near the present site of St. Augustine, sailed north and "veewed the coast all along with an unspeakable pleasure of . . . bewtye of the same." On May 1, Ribaut and his lieutenant, René de Laudonnière, and members of the crew rowed to shore near the mouth of a great river, which they named the River of May, now the St. Johns. They were greeted by "a good number of the Indians, inhabytants there, . . . without any taken of feare or dowbte . . . all naked and of a goodly stature, mighty, faire and aswell shapen and proportioned of bodye as any people in all the worlde, very gentill, curtious and of a good nature." Before sailing north, Ribaut and his men erected near the mouth of the river a stone pillar in which the "Armes of France were carved and engraved," thereby taking possession of the land for the King of France.

Moving on, Ribaut discovered eight more rivers and landed at Port Royal, now in South Carolina. There he left 30 men to hold the land for France, promising to return with provisions and supplies within six months.

Two years later, in 1564, with Ribaut confined to the Tower of London as a prisoner of the English, Laudonnière sailed from Europe with a group of Huguenots for the second time and cast anchor at almost the same spot at the mouth of the River of May. There crowds of Indians had gathered on the shore to bid them welcome. On learning of the approach of the French, the still friendly Indians had wrapped flowering vines and wreaths of bay leaves around the pillar of stone and had placed at its base baskets of fruit and grain, offerings of medicinal and edible roots, jars of perfumed oils, and a bow and a quiver of arrows. They were worshiping this column of stone as an idol.

The Huguenots rowed up the River of May and some six miles above the river's mouth in a "pleasant vale" at the base of a "mountain," now known as St. Johns Bluff, Laudonnière and his followers founded a French colony and built a

fort named Caroline in honor of King Charles. When Laudonnière climbed the bluff to survey the countryside, he saw "nothing else but Cedars, Palme, and Baytrees of so sovereigne odour, that Baulme smelleth nothing like in comparison." To him the surroundings seemed "so pleasant that those which are melancholicke would be inforced to change their humour." Chief Saturiba, "with whom friendship increased as the dayes increased," ordered the men of his tribe to help in the building of the fort.

This auspicious beginning made it appear that France would get a strong foothold in the New World, but not long afterward friendly relations with the Indians began to deteriorate. With the arrival of the Spaniard, Menendez, in 1565, the fortunes of the French colonists changed from bad to worse. The fort was burned, the French ships were wrecked off the coast in a storm, and the Huguenots who managed to reach land were overtaken by Menendez and killed mercilessly.

Jean Ribaut and René Laudonnière both wrote of their experiences and of the Indians. More important, however, were the accounts of the artist Jacque Le Moyne, who described the life of the colony and painted many pictures, and the carpenter Le Challeux, who wrote a book describing his experiences. These narratives and the engravings which the Flemish artist Theodore de Bry made later from Le Moyne's paintings, furnish

TROPHIES AND CEREMONIES AFTER A VICTORY

Returning victorious from their wars, the Florida Indians brought the legs, arms and scalps of their fallen adversaries to a designated place and with great solemnities attached them to tall poles. With the men and women of the tribe seated about him in a circle before the poles, the sorcerer-physician-priest cursed the enemy in a low voice. While he uttered a thousand imprecations, one of three men opposite him pounded on a flat stone with a club, marking time with the spells. The other two rattled pumpkins filled with small stones or seeds as they accompanied the sorcerer's curses with a chant.

invaluable source material concerning the French colony and the Timucua Indians of the sixteenth century. Without this material our knowledge of the Indians of Florida during that period would be meager indeed.

The Timucua Indians occupied that part of Florida which today includes Tampa, St. Petersburg, Gainesville, Lake City, Fernandina and New Smyrna with points in between. The Pensacola tribe was located in the far west of Florida. The Apalachees were in the Tallahassee region, the Calusas in the southwest portion, and the Ais, Jeaga and Tekesta tribes in the southeast section of the peninsula. The Tekesta Indians lived on almost the exact site of Miami today.

Some settlements were made up of individual villages with a chieftain for each village. In some instances there was a chief proper, who ruled over all the villages of the tribe.

The Timucua Indians are pictured as being muscular, large, well proportioned, and of a light brown color which the French called olivatre.

The priests were an important class in the Indian community. Like the medas of the Algonquins and the medicine men of other tribes, they united in themselves the priest, the physician and the sorcerer. With their bag of herbs and simples, they were always ready to serve the sick, and their skill in the healing art is credited with not infrequently effecting cures, especially of certain troublesome diseases. Their therapeutic methods are depicted in the accompanying illustration entitled, "How They Treat Their Sick." They are described as magicians "of such admirable subtlety as to restore what was lost, command the unwilling rain from heaven in time of drought, and foretell the position of an enemy or the result of a battle." As priests, they ordered festivals and led in these celebrations; too, they participated in grave deliberations. When their therapeutic art failed to cure, they were ever ready with spiritual power to console in the emergencies of pain and death.

Changing Income Distribution

Every physician should be interested in a recent study of the distribution of incomes reported by the New York Times.[1] Based on statistics of the National Bureau of Economic Research for 1950, it reveals that this country has "undergone a social revolution in the last four decades, and particularly since the Thirties," characterized by the expansion of national output and more equable distribution of the fruits of that expansion. It is particularly noteworthy that the trend toward equalization of incomes has been manifested by a "leveling up, rather than leveling down" process.

From the facts and figures assembled, it would appear that the very poor have become fewer by two thirds of their 1939 number. Also, the poor have become better off. An income of less than $2,000 a year was all that three out of four families could claim in 1939, but ten years later only one out of three fell into that class. Those in higher income brackets have become more numerous, too — one family in about 50 with a $5,000 or more income and one out of 100 with $10,000 or over in the late Thirties in contrast to one out of six and one out of 20 in these respective groups in the late Forties.

Certainly those who devote their lives to fighting disease and disability rejoice in the apparently hopeful outlook for the poor and trust that their lot will continue to improve. The other side of the picture, however, is not to be ignored. Without doubt, the nation's productivity has increased steadily and without interruption, but the depression years brought increasing public debt, and then war brought almost uninterrupted inflation, making social gains problematic. The euphoria engendered by expansion of the currency unquestionably, up to a certain point, "masks the oncoming cramps of the inevitable later sharp contractions." Time will indeed tell.

More and more, the national product is being dispensed or disbursed by government, or at least disposed of in one way or another, abroad if not at home. For better or worse, the various subsidies have undoubtedly had a role in the changed distribution of income. What portends with the government now the largest employer and the tax structure devouring the take-home pay of all citizens?

Citing the foregoing facts and figures, the New York State Journal of Medicine comments editorially upon the status of the physician with regard to income:[2]

What interest does this have for physicians? If the poor and the very poor are better off than before, what is the status of a doctor with a wife and two children in 1952? He and his family must pay the current high prices for everything they consume like everyone else, but notwithstanding the nearly 137 per cent increase (average gross earnings before tax deductions) in earnings of persons in the medical and health field between 1939 and now, this apparent gain is offset in the same period by inflation and taxes. According to the Daily News[3] the head of such a family must now earn $6,783 to equal the $3,000 he earned in 1940. Also he must now earn $11,540 to equal the $5,000 he earned in 1940; and he must now earn $25,800 to equal the $10,000 he made in 1940. If such a doctor made $25,000 in 1940, in 1952 he would have to acquire $121,000 to equal it after inflation and taxes get through with him and his family. A significant number of doctors come within the $3,000 to $25,000 group to make the above comparisons of considerably more than academic interest.

As of now the Federal government is taxing more than 25 per cent of the national income and is also running a deficit. Prices in the United States have reportedly nearly doubled since 1939, so cutting nearly in half all dollar savings, all insurance, all pensions.

This seems to be the picture as of now. As the man said during his first airplane trip, "It's a beautiful ride, while it lasts."

And then where are we when the ride is over? It seems timely to ponder that question.

1. March 5, 1952.
2. Distribution of Income, New York State J. Med. 52:1121-1122 (May 1) 1952.
3. March 12, 1952.

Static Electricity Dangers

All hospital staff members surely are agreed that hospital operating rooms and other anesthetizing areas should be made as safe for patients and personnel as possible in the light of modern science and technology. They should therefore give serious and prompt attention to a recent report of the United States Bureau of Mines on a two and a half year study of static electricity in hospital operating suites.

To reduce to the minimum the hazard of anesthetic explosion, "major changes are needed in most hospitals," the report stated.[1] An electrical engineer, a physical chemist and a physical science aide made numerous tests in 78 operating rooms, 22 delivery rooms and 16 hospital corridors of 14 hospitals. They concluded: "There is probably no combination of equipment and personnel activity anywhere more liable to produce casual, dangerous charges of static electricity than that found at present in the anesthetizing areas of most hospitals."

Such a statement warrants due consideration, for the Bureau of Mines has had its experts studying the dangers of static electricity for more than 20 years in an effort to promote safety in mines. Remedies have been suggested from time to time over the years. The report cites the Journal of the American Medical Association as early as May 17, 1924, but states that "it appears, however, that very few hospitals have made a studied and continued effort to apply the remedies effectively."

The authors suggest a number of simple, effective improvements hospitals can initiate while waiting for major changes and for the appearance of proper material and equipment. These recommendations include:

1. Conductive rubber mattresses, pads and pillows should be substituted for the ordinary variety as soon as they are available. (Conductive substances pass on the electricity before a dangerous charge can be built up.) 2. Conductive shoes should be worn by all personnel. 3. Suitable conductive breathing tubes, masks and bags should be installed on anesthesia machines. 4. Stools with smooth, rounded feet and bare metal tops are the most satisfactory. 5. Outer garments of wool, silk or synthetics such as nylon, rayon or orlon should be prohibited in anesthetizing locations. 6. A suitable measuring instrument should be installed in a convenient and safe place for testing conductivity of shoes of all personnel entering anesthetizing area.

In the interest of increased safety, medical staffs will undoubtedly wish to inquire into conditions in their respective hospitals. This 64 page report is available at the Bureau of Mines, 4800 Forbes St., Pittsburgh 13, Pa. Meanwhile, certainly the wearing of dangerous outer garments of the materials mentioned can be prohibited by operating floor regulations, if such regulations do not now exist.

As a point of departure, recognition of the hazard is of course of paramount importance. It is encouraging therefore to note that the National Bureau of Standards is now enlarging its research and standardization program of static electricity hazards "to meet a growing demand for this information" from hospitals and other institutions.[2]

1. Changes in Operating Rooms to Cut Down Static Electricity Recommended, Capitol Clinic 3:4 (Feb. 12) 1952.
2. Bureau of Standards Enlarges Research on Static Electricity, Capitol Clinic 3:3 (April 29) 1952.

The Editor Invites Your Contributions on Data of Notable Interest

A.M.A. President September Visitor to Florida

Dr. Meredith Mallory, Sr., of Orlando, state chairman of the Florida Medical Committee for Better Government, announces that Dr. Louis H. Bauer, President of the American Medical Association, will be in Jacksonville the weekend of Sept. 6-7, 1952 as the guest of the committee. He will be the principal speaker at the committee's third annual meeting.

The FMCBG extends an invitation to all members of the Florida Medical Association and their wives to attend the meeting and assist in welcoming the distinguished A.M.A. President.

The general chairman for the meeting is Dr. O. E. Harrell, with Dr. Raymond R. Killinger serving as adviser.

On the agenda for the weekend are two luncheons and a dinner and other affairs for committee members and guests. Arrangements are also being concluded for one or more nonmedical speakers of national political importance.

The meeting will be opened with a luncheon at 12:30 p.m. on Saturday, September 6, at the George Washington Hotel Auditorium. The public will be invited. This will be followed at 5:30 p.m. by cocktails at the Mayflower Hotel with dinner and entertainment at 6:30 p.m. on the Mayflower Roof Garden. At 8:30 p.m. there will be a public meeting at the George Washington Hotel Auditorium.

On Sunday, September 7, there will be a business session and election of officers at 9:30 a.m. at the George Washington Hotel. At a luncheon at 12:30 p.m. in the same hotel, Dr. Bauer will be introduced to the members and guests by Dr. Robert B. McIver, President of the Florida Medical Association, and will address the gathering.

The FMCBG feels that the doctors of Florida have been greatly honored by Dr. Bauer's acceptance of its invitation to visit our state. This pioneer organization, like similar groups in California, Maryland and a few other states, functions apart from any organized county, state or national medical society. It is entirely nonpartisan and nonprofit, and seeks to promote more interest and participation in government on the part of physicians. At its second annual meeting in Miami on Oct. 5-7, 1951, the committee was honored by the presence of Dr. John W. Cline of San Francisco, President of the American Medical Association at that time. In a public address in Miami's Bayfront Park Auditorium on October 7, Dr. Cline predicted that government control over the American medical system, in one form or another, again probably would become a live political issue in 1952. He warned that "government-controlled medicine would be only the first big step toward destruction of the American system of free enterprise, the first big feather in the cap of the Socializers." He concluded his speech with this promise: "The doctors of America will be vigilant, ready and active as will likewise be the American public, regardless of party affiliation."

Dr. Bauer became the new president of the A.M.A. at its 101st annual session on June 10, 1952 in Chicago. In his inaugural address he pledged himself and the A.M.A. to continue to fight for Voluntary Health Programs and to oppose Compulsory Health Insurance. He challenged both political parties to see that the people of the United States are given a government that serves rather than a government that dominates. He is a forceful, dynamic champion of the freedom of medical practice and is spearheading the fight against Socialism that is creeping over this country.

A member of the Board of Trustees of the American Medical Association since 1944, Dr. Bauer has served as Chairman of the Board since 1949. He became a member of the Executive Committee in 1947 and was Chairman of the Committee in 1948. He has been a member of the House of Delegates for many years, has served as Chairman of the Council on Medical Services and is a member of the Committee on Scientific Exhibits. A resident of Hempstead, N. Y., he had previously been President of the Nassau County Medical Society and of his district branch medical society, and President of the Medical Society of the State of New York following a notable career as speaker of its House of Delegates.

Dr. Bauer was born in Boston and was graduated cum laude from Harvard Medical School. He interned at Mercy Hospital, Springfield, Mass., was an honor graduate of the United States Army Medical School and of the United States Army School of Aviation Medicine, and a graduate also of the Army War College in 1926. Dr. Bauer spent 13 years in the Army as a medical officer and was the first Commandant of the Army School of Aviation Medicine. He is now a Colonel, United States Army, retired. He was also the first medical director (1926-1930) of the

Louis H. Bauer, M.D.

Aeronautics Branch of the United States Department of Commerce, now the Civil Aeronautics Administration.

Since 1930, Dr. Bauer has been engaged in the private practice of cardiology at Hempstead. He is attending cardiologist at Nassau Hospital, Mineola, and a consultant at Meadow-Brook Hospital in his home town and some six other hospitals in nearby communities. A diplomate of the American Board of Internal Medicine, he is also a fellow of the American College of Physicians, and a member of the American Heart Association, the New York State Public Health Council, and the Aero Medical Association, of which he was the first president (1929-1931). He is an honorary member of Phi Beta Kappa. Representing the American Medical Association, he served as a delegate to the American Council on Rheumatic Fever. He received the distinguished service award of the Nassau Daily Review-Star in 1949 and was the first recipient of the Lister Award of the Aero Medical Association and of the John Jeffries Award of the Institute of Aeronautical Sciences.

For 21 years, Dr. Bauer has been Editor-in-Chief of the Journal of Aviation Medicine. He has contributed many articles on aviation medicine, cardiology and medical economics to medical journals and is the author of a textbook on Aviation Medicine, a book entitled "Private Enterprise or Government in Medicine," and chapters on aviation medicine in various textbooks and encyclopedias.

Dr. Bauer served as Secretary of the American Committee of the World Medical Association and as a member of the Council of that organization. Since 1948, he has been Secretary General of the World Medical Association. His election to the high office of President of the American Medical Association is an honor richly deserved for outstanding and faithful service to the medical profession, to the public and to his country.

The Florida Medical Committee for Better Government confidently expects that the members of the Florida Medical Association and their wives will attend in large numbers its third annual meeting, participate in all of its activities and extend to Dr. Bauer a rousing welcome.

Report of Delegates to A.M.A. Chicago, June 9-13, 1952

Even though the proceedings of the 101st Annual Session of the American Medical Association have been presented in the form of a "brief report" in the June 28th and July 5th issues of The Journal of the American Medical Association, they are far too lengthy for the busy practitioner of medicine to read in detail. Hence it becomes the duty of the Florida delegates to report even more briefly on some of the happenings at this great convention and to make reference by page number only to the more intricate details of some of the proceedings.

To give some idea of the immensity of this last annual convention in Chicago, it is noted that nearly 12,000 physicians and more than 13,000 guests registered for the meeting. At this meeting were offered more than 400 scientific papers, 300 medical exhibits and 375 technical exhibits. The space devoted to these technical exhibits occupied more than 2 miles, which prevented the average visitor from obtaining more than a fleeting glimpse of these valuable presentations. The question has been raised once more, as it has

many times in the past, is not the convention of the American Medical Association something too huge even to comprehend? Officers and other members of the Association participated in more than 30 events, which involved radio or television broadcasts. Many coast to coast hook-ups sent forth all over the country the many scientific exhibits and other special presentations. Thirty million Americans are estimated to have watched each program and for the first time an operation was televised on a nationwide hook-up. The inauguration of the President, Dr. Louis H. Bauer, was broadcast over more than 200 ABC and Mutual Broadcasting stations throughout the United States, Hawaii and Alaska. Operations were telecast over closed circuits from the operating rooms of Wesley Memorial Hospital. Truly it can be said that the last Annual Session of the American Medical Association was called by some visitors "the World Fair of Medicine." Aside from the many physicians of America registering at the convention, representatives from more than 40 foreign countries, representing 6 continents, were also present. One hundred science writers and reporters released words through their press outlets which numbered into the hundreds of thousands.

OFFICERS ELECTED.—The House of Delegates elected Dr. Edward J. McCormick, of Toledo, Ohio, President-elect of the American Medical Association. He will take office at the next Annual Session in New York City next June. Dr. Dwight H. Murray, of Napa, Calif., was re-elected to the Board of Trustees and subsequently was re-elected by the Board to be Chairman. Dr. James R. Reuling, Bayside, N. Y., was elected as Speaker of the House of Delegates, succeeding Dr. F. F. Borzell of Pennsylvania. Dr. E. Vincent Askey, Los Angeles, was elected Vice Speaker. Dr. J. J. Moore, Chicago, was re-elected Treasurer, and Dr. George F. Lull, Chicago, was re-elected Secretary.

Florida can be particularly proud of its representation on important Councils by virtue of the fact that Dr. Homer L. Pearson, Jr., Miami, was elected to succeed himself as a member of the Judicial Council for a term of five years.

AMERICAN MEDICAL EDUCATION FOUNDATION.—At this annual meeting an additional contribution to the fund in the sum of $2,000 was presented by the American College of Radiology. The Chicago Medical Society contributed $25,000. Dr. Mather Pfeiffenberger of Illinois contributed $1,000 and the Woman's Auxiliary of the American Medical Association, $10,000.

It is noteworthy that the council of the Illinois State Medical Society voted recently to increase the annual dues of its members by $20.00, this increase to be used for the American Medical Education Foundation.

The general scientific meetings revealed a wealth of postgraduate medical educational material. Dr. Alton Ochsner of New Orleans deplored the extremely low five year survival rate in cancer of the stomach, which is now no better than 5 to 10 per cent, even in the best teaching institutions. Dr. Ochsner pointed out that any man over 40, previously well, who has shown anorexia severe enough to cause 15 pounds of weight loss, should undergo exploration of the gastrointestinal tract. Early cancerous lesions less than ½ cm. in diameter may oftentimes be revealed.

In the Section on Gastroenterology and Proctology it was revealed that neoplasms of the rectum were found in 10 per cent of 3,500 patients subjected to routine sigmoidoscopy. It was concluded that this procedure should be carried out routinely in patients over 40 years of age.

In the Section on Laryngology, Otology and Rhinology it was re-emphasized that poliomyelitis following nose and throat operations is more likely to be bulbar in type.

In the Section on Miscellaneous Topics it was the consensus of most of the panel discussants that there is no contraindication to the long term use of cortisone and ACTH provided a close watch is kept for concurrent infections, hypertension, electrolyte disturbances and other untoward reactions. Dr. B. Rose of Montreal reported three cases of osteoporosis with spontaneous fractures in patients under long-term therapy. This tendency was counteracted by the administration of calcium, testosterone, and a high protein diet. It was further revealed by Dr. A. H. Holland of Chicago that only 1.9 per cent of 4,376 patients receiving ACTH had immediate allergic reactions to the drug, while 7.5 per cent acquired resistance to ordinary doses. Some of the resistant patients again responded when thyroid extract was administered or when the dose was increased.

It is interesting to note that Drs. Millikan, Lundy and Smith of Rochester, Minn., were unable to confirm reports of beneficial effects of

procaine block of the stellate ganglion in acute cerebral infarction.

In the Section on Nervous and Mental Diseases Dr. H. W. Kumm of New York stated that the question of whether or not gamma globulin actually affords significant protection against poliomyelitis might be answered by the end of this summer when extensive experiments will be concluded. He was optimistic about the ultimate feasibility of active immunization with attenuated strains of the virus.

In the Section on Pathology and Physiology Dr. H. J. Corper of Denver warned against overoptimism concerning the chemotherapy of tuberculosis, since the bacillus has successfully resisted all agents used to date.

In the Section on Urology Dr. J. K. Lattimer stated that isonicotinyl hydrazide has given impressive preliminary symptomatic results in the therapy of renal tuberculosis. Dr. A. J. Butt of Pensacola stated that the use of hyaluronidase by subcutaneous injection prevented the formation of new stones or enlargement of old stones in a number of patients with recurring renal calculi.

Special Awards.—Dr. Paul Dudley White of Boston received the 1952 Distinguished Service Award of the American Medical Association for his work in cardiology.

Proceedings of the House of Delegates.—In the address of the Speaker, Dr. F. F. Borzell, it was stated that an analytical study of the House of Delegates disclosed that the average age of the members of the House was 59 years and the average length of service five and one-half years. It was further disclosed at this session that 14 new Delegates were seated and 18 others were in their first year of service. The age groups of the House of Delegates were as follows:

40 to 49 inclusive	21 or 11%	averaging 46
50 to 58	78 or 42%	averaging 55
60 to 69	68 or 36%	averaging 64
70 to 79	20 or 11%	averaging 72

The address of the President, Dr. John W. Cline, is recommended to all members of the Association for most careful reading. It is carried on pages 853-856, inclusive, of the June 28 issue of The Journal of the American Medical Association.

Interesting information and decisions made by the House of Delegates at this Session are:

1. Tax Deduction for Postgraduate Study.—No decision favorable to the individual undergoing this training could be obtained from the Commissioner of Internal Revenue. The Association has filed a brief and has obtained the services of an experienced tax lawyer in Washington as counsel in an effort to have this interpretation of legislation changed.

2. Fluoridation of Public Water Supplies.—Based upon a statement by the Council on Pharmacy and Chemistry, the Association endorsed the basic principle and advised the committee that fluoridation of public water supplies in a concentration not exceeding one part per million is nontoxic.

Honoraria for President and President-Elect.—The Board of Trustees has voted to authorize an honorarium of $50.00 a day for the President and President-elect for every day they are away from their homes on official American Medical Association business, in addition to the regular per diem ($25.00) and travel allowance which they are now receiving. This action is to be retroactive to June 15, 1951 in the case of the President, Dr. Cline, and the President-elect, Dr. Bauer.

1953 Dues of the Association.—The Board of Trustees recommends that the dues of active members of the American Medical Association be $25.00 for 1953. Membership dues include subscription to The Journal of the American Medical Association unless a member requests another scientific journal published by the Association in lieu of The Journal.

Non-Service-Connected Disabilities of Veterans and Their Medical Care.—Several resolutions were introduced on this subject and a special committee of the Board of Trustees, headed by Dr. Elmer L. Henderson, presented an interim report. The final report of this special committee is eagerly awaited at the interim session of the American Medical Association in Denver, December 1952.

Licensure or Certification of Clinical Psychologists.—The reference committee to which this problem was referred recommends disapproval of the recommendation for licensure or certification and recommends its referral to the Council on Medical Education and Hospitals for further study.

Report of the American Medical Education Foundation.—In the first year a total of $745,000 was raised from medical sources. Gifts from industry and business added additional funds for the grand total of $1,600,000. Grants were made on an average of a little more than $20,000 per school during the first year. It is hoped to raise

more than $2,000,000 in 1952, and it is further hoped that this will be more than matched by contributions from business and industry, and by the end of the year the Committee hopes that sufficient progress will be made in fund raising to assure an annual $5,000,000 fund that may be granted our medical schools. Already there have been contributions by 2,500 individual physicians, an increase of 39 per cent over the total number of individual contributors for the entire year 1951. The sum contributed so far by individual physicians, which now stands at $121,000, also exceeds the total of $91,000 raised from this source for the entire year of 1951.

REPORT OF COORDINATING COMMITTEE.—Dr. Elmer L. Henderson, Chairman, revealed that the expenditure on Public Relations of the Association in its effort to ward off the progress of socialized medicine amounted to only $100,000 for the first six months of this year. A saving of one-half million from the campaign budget last year and the same amount the year before, aided the Association in contributing a million dollars to the American Medical Education Foundation.

REPORT OF COMMITTEE ON BLOOD BANKS.—Since the last report high levels of blood collection for defense purposes were maintained through December and until early this year. There has been a gradual decline through the past three or four months and as of this time plasma processing plants are not being supplied to capacity. From Red Cross data it is learned that for the period, December 1, 1950 through April 30, 1952, a total of 2,558,000 units of blood were collected for defense purposes, of which 2,094,000 were collected through Red Cross regional and defense centers and 464,000 units were collected through cooperating blood banks. In the period July 1, 1950 to March 31, 1952, a total of 209,000 units of whole blood were shipped to the military for overseas use and 2,110,000 units were shipped for the military to plasma processing plants. Approximately only 9 per cent of defense blood obtained in this country was shipped overseas as whole blood through the armed forces publicity program.

Actions on Resolutions:

1. RESOLUTION ON NEGRO PHYSICIANS IN NORTH CAROLINA.—It was recommended that the resolution presented by the North Carolina delegation, to include as a component unit of the American Medical Association the Negro medical association of North Carolina, be referred to the Board of Trustees for further study. This same resolution was disapproved last year and, no doubt, the same action will follow this year. It has been the contention of the American Medical Association that such matters should be handled at local levels.

2. RESOLUTION ON RESTRICTION OF MEMBERSHIP IN THE AMERICAN MEDICAL ASSOCIATION.—This resolution was introduced by the New York delegation and it simply stated that, in view of the fact that encouraging progress had been noted in the favorable policy toward admission of Negro physicians to membership in county medical societies in Maryland, Missouri, Florida, District of Columbia, Oklahoma, Virginia and Delaware, the House of Delegates be instructed through the Secretary of the Association to send a copy of this resolution to each constituent association and society, to the end that all men and women professionally qualified shall be eligible for membership in the American Medical Association and its component constituent associations without regard to race, color or creed. This resolution was intended as a resolution of information and not one of action.

3. RESOLUTIONS ON SPECIALTY BOARD FOR MICROBIOLOGY.—Nine resolutions dealing with the same subject were presented before the House of Delegates. The Reference Committee brought in the following recommendation, which was adopted: "The Council on Medical Education and Hospitals has not recommended the approval of an American Board for any non-physician group, and hence your reference committee feels it is unnecessary to take any action on these resolutions at this time but should await the report to the House of Delegates of the study of the Council on Medical Education and Hospitals and the Board of Trustees on the subject."

RESOLUTION ON PROVISION OF FUNDS TO DEFRAY EXPENSES OF SECTION DELEGATES.—This resolution was introduced by the Section on Experimental Medicine and Therapeutics. The Reference Committee recommended that the House of Delegates instruct the Board of Trustees to pay the transportation and per diem allowance, as determined by the Board of Trustees, of the Section Delegates incident to attendance of the sessions of the House of Delegates. This resolution was adopted.

RESOLUTION ON CANDIDATES FOR PUBLIC OFFICE.—The House of Delegates went on record by the following resolution: "Resolved, By the

House of Delegates that The American Medical Association does not support any political party or any candidate for elective public office."

Resolution on Change of Date for Deciding Apportionment of Delegates.—The By-Laws of the American Medical Association were amended to the effect that the date of deciding on apportionment of delegates of a constituent association be changed from December 1st to December 31st of each year. The reason given for this change is that in many states medical societies are still collecting dues from their members during the month of December each year and find themselves possibly in a position of disadvantage if the apportionment is based on paid membership as of December 1st.

Resolution on Osteopathy.—This resolution, introduced by the California delegation, stated in part: "Whereas, This objective would be furthered by eventual amalgamation of the medical and osteopathic professions in which future graduates and practitioners would have equal training of the highest scientific caliber; therefore be it Resolved, That the House of Delegates of the American Medical Association urges immediate action to accomplish an eventual amalgamation of the medical and osteopathic professions under circumstances which would be acceptable to the Judicial Council and the Board of Trustees of the American Medical Association and that these bodies be requested to recommend specific procedures for the accomplishment of these objectives." The Reference Committee recommended that this resolution be referred to the Board of Trustees to appoint a committee for further study and consultation with the American Osteopathic Association IF and WHEN requested. This report was adopted unanimously.

Resolution on Limitation of Federal Taxation.—This resolution was to the effect "That the House of Delegates of the American Medical Association go on record as favoring an amendment to the Constitution of the United States limiting the taxing power of the federal government." The resolution was unanimously adopted by the House of Delegates.

Resolution on Change in Name of Grievance Committee.—Dr. Joseph F. Shuffield, Arkansas, presented the following resolution, which was referred to "an appropriate" reference committee for report at the December interim session: "Resolved, That the name Grievance Committee be changed to Professional Relations Committee."

Supplementary Report of Board of Trustees on H.R. 7800.—The readers of The Journal are requested to read in detail this report so that a thorough understanding of the position of the House of Delegates in relation to this legislation may be used to refute arguments that the American Medical Association was attempting to deny the beneficiaries of Social Security their just benefits. This report was published on page 948 of the July 5 issue of The Journal of the American Medical Association.

Place of 1955 Annual Session.—On recommendation of the Board of Trustees, the House of Delegates voted to accept the invitation to hold the Annual Session in Atlantic City, N. J., in 1955.

The House of Delegates gave Dr. F. F. Borzell, the retiring Speaker, a rising vote of thanks for his services to the House over the past few years. Dr. Borzell's final words were, "As I ring down the gavel on this 101st Session, I wish to express my extreme appreciation for the courtesies that you have shown me, for the opportunity that you have given me to serve American medicine and the American Medical Association as your Speaker, and I wish for this House all of the good fortune possible. I hope it will maintain that same integrity, that same courageous, unswerving course of devotion toward American medicine it has shown in the past, and that you will prevent, by your activities, America from going anywhere but in the direction of liberty and freedom."

A cordial greeting and message of thanks was extended to the Chicago Medical Society and the Illinois State Medical Society for the hospitality and fine treatment received.

The House adjourned sine die at 4:40 p.m., Thursday, June 12.

Respectfully submitted,

Louis M. Orr, II
Herbert L. Bryans
Frank D. Gray (Alternate)

1952 Medical District Meetings

"A", Panama City	October 27
"C", St. Petersburg	October 29
"D", Fort Pierce	October 30
"B", Daytona Beach	October 31

Observations Relating to the Use of Gamma Globulin in Prevention of Paralytic Poliomyelitis

Carrying the approval of the Committee on Blood Banks of the American Medical Association, a timely statement regarding the use of gamma globulin in the prevention of paralytic poliomyelitis comes from the Sub-Committee on Blood of the Health Resources Advisory Committee of that association. The statement in full follows:

"Whether gamma globulin will be effective in the prevention of paralytic poliomyelitis is not now known. On the basis of animal experiments and preliminary study on humans, it is possible that globulin will have value in human poliomyelitis, but serious questions remain to be answered before such a hope can be substantiated. Nevertheless, public dissemination of information on the status and objectives of current studies, incompletely presented or misunderstood has created a serious demand for gamma globulin which cannot be met.

"Virtually the entire output at current production rates is required to meet the demand for prevention or modification of the course of measles and infectious hepatitis.

"Under the circumstances, it is obvious that the existing limited supply and current production of gamma globulin should be reserved for use in these diseases in which its efficacy has been established."

Graduate Medical Education

During the month of June the Department of Medicine of the Graduate School of the University of Florida, in cooperation with the Florida Medical Association and the Florida State Board of Health, presented three excellent graduate courses to the physicians of Florida.

The first course, held on June 16, was presented by the Faculty of the Department of Medicine. At the request of the Bay County Medical Society, a Seminar on Obstetrics and Gynecology was conducted by Dr. Chas. J. Collins, Chairman, Division of Gynecology, and Dr. E. Frank McCall, Chairman, Division of Obstetrics, in Panama City. A round table discussion during the dinner hour continued late into the evening. The speakers were most favorably received, and the reaction on the part of the physicians attending justifies further graduate courses of this type in districts not so easily accessible to the larger medical centers.

The next scheduled course is one in internal medicine and laboratory findings, which will be given in the fall at Lakeland. The members of the Faculty presenting this course will be Dr. Karl B. Hanson and Dr. Lucien Y. Dyrenforth.

The Seminar on Diagnosis with particular reference to the thyroid diseases, which was held in Jacksonville, June 19-21, showed evidence of much preparation on the part of the lecturers. Throughout the three day period, the lectures gave evidence of perfect coordination on the part of the three participating physicians, Dr. Lewis M. Hurxthal, internist, Dr. Hugh F. Hare, roentgenologist, and Dr. William A. Meissner, pathologist, all of the Lahey Clinic in Boston. It would be difficult to find a more advanced course anywhere in the country this year.

The Twentieth Annual Graduate Short Course was presented the week of June 23-28. As usual, this course was held the last week in June, which has come to be accepted as the best time for it.

Those who had been in attendance over the years indicated by their comments that the lectures as a whole were as good this year if not better than in any past year. Some of the lectures were on research recently carried out, and the conclusions are of vital interest to physicians throughout the country.

FLORIDA BLUE SHIELD

Blue Shield Benefits

For the third time since it was organized the Blue Shield Plan has stepped forward with broadened benefits. Each new increase in benefits brings the Plan closer to its goal of providing greater health care protection for the people of Florida. Even now plans are under way and studies are being made for further increases which may very possibly go into effect by the end of the year.

A brief review of the history of the various increases in benefits will show the strides which have been made by Blue Shield of Florida since its organization in 1946.

The Florida Blue Shield Plan as originally organized, was a plan to cover surgical care only. In 1948 many fees for surgical procedures were adjusted upward, but at that time the Plan had not gained sufficient experience to launch a program for the coverage of medical care. Then in

1950, after it was felt that sufficient experience had been gained, and after actuarial studies were made, the first step was taken toward coverage for medical care, that step being the payment of $5.00 a day for 28 days a year for in-hospital medical care beginning on the fourth day of hospitalization. The increased benefits which became effective on August 1, 1952, further broadened the coverage for medical care. These new benefits are listed below and are compared to the benefits provided in the old contract in order that one may easily see the increases which have been made.

	New Coverage	*Old Coverage*
Increased schedule for certain surgical procedures	$250 Maximum	$150 Maximum
Unrelated surgical procedures during same stay in hospital	$250 Maximum	$150 Maximum
Surgery for congenital anomalies covered from birth	$250 Maximum	Not covered
Days allowed per contract year for in-hospital medical care at $5 per day	50 Days $250 Maximum	28 Days $140 Maximum
Medical care for coronary thrombosis or occlusion during first three days in hospital	$50 Maximum	Not covered
Medical care for diabetic coma during first three days in hospital	$50 Maximum	Not covered
X-ray therapy for treatment of cancer	$200 Maximum	Not covered
X-ray therapy combined with surgery for treatment of cancer	$250 Maximum	Surgery only covered
Anesthesia allowance for outside M.D. anesthetist	$37.50 Maximum	$10 Maximum
Maternity Benefits—$50 for normal delivery	In home, doctor's office or hospital	In hospital only

The Blue Shield Plan will be happy to furnish further information about these new benefits to any physician desiring it. The Plan's address is 532 Riverside Ave., Jacksonville.

Medical Officers Returned

Dr. Freeman D. Stanford, who entered military service on Oct. 17, 1950, was released from active duty on April 24, 1952, with the rank of Captain, A.A.F. His address is 502 East Colonial Drive, Orlando.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Alspach, Walter L., Miami
Angel, Norman S., Miami
Brandt, Ira K., Coral Gables
Cassel, Chester, Miami
Clark, Edward J., Callahan
Fox, Sidney, Miami
Freed, Leonard, Tampa
Gallo, William J., Hollywood
Herbert, Alpha N., Miami
Hogg, Bruce M., Miami
Johnson, Samuel H. (Col.), Miami
Lenzen, John L., Winter Haven
Ovitz, Morris, Miami
Patterson, William A., Jr. (Col.), Miami
Sloane, David, Orlando
Smith, James H., Miami
Stanford, Freeman D., Orlando
Stoner, Edward W., Oviedo
Trombly, Frank W., Miami
Yonge, Henry M., Ann Arbor, Mich.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Carl M. Midkiff of Miami Shores announce the birth of a son, Randall Preston, on April 18, 1952.

Dr. and Mrs. Benjamin G. Oren of Miami announce the birth of a daughter, Marianne, on June 29, 1952.

Dr. and Mrs. Thomas G. Ritch of Jacksonville announce the birth of a daughter, Janice Marian, on July 1, 1952.

Dr. and Mrs. John T. Stage of Jacksonville announce the birth of a son, Kirk Mason, on July 3, 1952.

Dr. and Mrs. William J. Phelan of Jacksonville announce the birth of a son, Thomas Sullivan, on July 12, 1952.

Dr. and Mrs. George I. Raybin of Jacksonville announce the birth of a daughter, Susan Eileen, on July 15, 1952.

Marriages

Dr. Steve R. Johnston and Miss Barbara Hutchinson, both of Fort Pierce, were married recently.

Deaths - Members

Riesenbeck, Leo H., Miami	June 12, 1952
McKenzie, Albert C., Jacksonville	June 20, 1952
Mills, Herbert R., Tampa	June 27, 1952
Tillman, George C., Clearwater	June 29, 1952
Taylor, Joseph E., DeLand	July 10, 1952
Skiff, Francis S., Fort Lauderdale	July 12, 1952
Stollenwerck, A. D., Jacksonville	July 29, 1952
Adams, C. LeRoy, Jr., Live Oak	Aug. 3, 1952

Deaths — Other Doctors

Clark, George T., Bradenton	July 17, 1952
Weaver, Cleo Earl, LaBelle	July 18, 1952

STATE NEWS ITEMS

Dr. Samuel M. Day, Association secretary and treasurer, Jacksonville, has moved his private offices to 415 Medical Arts Building.

The following members of the Association recently attended postgraduate courses at the Cook County Graduate School of Medicine: Drs. Roy Ray, Daytona Beach; Martin E. Buerk and Thomas Whitehead, Delray Beach; Robert L. Elliston, Fort Lauderdale; and Clarence W. Lynn, Orlando.

Dr. Arthur J. Butt of Pensacola recently presented papers before the Section of Urology, American Medical Association, Chicago, and the American Urological Association, Atlantic City, on "The Treatment and Prevention of Renal Lithiasis with Hyaluronidase." Scientific exhibits concerning this subject were awarded the Certificate of Merit from the A. M. A. and the first prize for clinical research from the A. U. A.

Dr. Courtlandt D. Berry of Orlando has returned to his practice after spending a year in Puerto Rico where he helped to plan a program for the early discovery of cancer in women. The program is being sponsored by the medical school of the University of Puerto Rico and the Insular Health Department. In addition, Dr. Berry held clinics and acted as consultant in Puerto Rican hospitals, served as consultant to the U. S. Army General Hospital of San Juan and conducted weekly instruction for medical officers stationed at Ramey Field.

Dr. Floyd K. Hurt of Jacksonville has been elected executive committee chairman of the Duval County Unit of the American Cancer Society.

Dr. Edwin P. Preston of Miami has been elected president of the Heart Association of Greater Miami. He succeeds Dr. Earl R. Templeton of Miami Beach. Other officers are Drs. Milton S. Saslaw, Miami Beach, and Morton M. Halpern, Miami, vice presidents; and Jack L. Wright, Miami, secretary.

Dr. Frederick K. Herpel of West Palm Beach was a guest speaker along with a member of the Florida State Dental Association at a recent meeting of the Palm Beach County Bar Association. The subject for discussion was "Public Relations."

Dr. Leonard L. Weil of Miami Beach has been elected president of the Dade County Academy of General Practitioners replacing Dr. Vincent P. Corso of Miami. Other officers include Drs. Manning J. Rosnick, vice president, Walter W. Sackett, Jr., secretary-treasurer, both of Miami, and T. D. Sandberg, three year trustee, of Coral Gables.

Dr. Milton S. Saslaw of Miami Beach, past chief of the medical staff of the National Children's Hospital at Miami, was recently presented with a plaque in recognition of his services to the Hospital. Dr. Saslaw was succeeded as chief of the medical staff by Dr. Herbert Eichert of Miami.

Dr. Irwin S. Leinbach of St. Petersburg recently attended the joint meeting of the Orthopedic Associations of the English-speaking world in London. He is also visiting Dr. Ian Winchester, chief resident surgeon at the largest orthopedic hospital in the United Kingdom. He will visit several clinics in Europe for the study of new methods of treatment of arthritis.

Dr. Herman Boughton of Miami Beach was a recent guest speaker at the women's division of the North Miami Beach Chamber of Commerce. A film on "Self Examination of the Breast" was shown.

Dr. James F. Lyons of Coral Gables recently attended the International Congress of Physical Medicine in London.

Dr. Edward G. Haskell, Jr., of Branford spoke on "Socialized Medicine" at a recent meeting of the Mayo Rotary Club.

Dr. Stewart Thompson was recently awarded a citation and emblem denoting twenty years of service with the Florida State Board of Health. He was included among 22 employees and former employees of the Board of Health receiving citations and emblems for length of service. Dr. Thompson was employed on April 13, 1918, and resigned in 1937. At the ceremony, which was held on the steps of the old Florida Health Building, Dr. Robert B. McIver, a member of the State Board for the past ten years, was a guest speaker. The citations and emblems were awarded by Dr. Wilson T. Sowder, State Health Officer.

Dr. Alfred S. Massam of Bartow, county hospital superintendent, addressed members of the Exchange Club of Bartow at a recent dinner meeting, outlining the functions of the hospital and some of the further services which he hopes to make available in the future.

Dr. Albert C. Kirk, Sr., of Orlando, former Orlando city physician for seven years, was named as county physician recently. For the past two years he has been staff physician at the Central Florida State Tuberculosis Hospital.

Drs. Paul H. Martin, Cornelia M. Carithers and Turner Z. Cason of Jacksonville received citations and service pins recently for ten years of service to the Duval County Chapter, National Foundation for Infantile Paralysis.

Drs. Morris B. Seltzer of Daytona Beach, Irving L. Alberts of Miami Beach, and Erasmus B. Hardee of Vero Beach have been appointed by Governor Warren as members of the Florida State Board of Medical Examiners, and Dr. Frank D. Gray of Orlando has been reappointed to the Board for a third term.

The annual Fall Meeting of the Postgraduate Assembly of Endocrinology and Metabolism, which is sponsored by the Endocrine Society, will be held in Miami Beach at the Roney-Plaza Hotel, Nov. 3-8, 1952. Dr. Carlos P. Lamar of Miami is the local chairman for the Society.

The Georgia Heart Association extends to all doctors of Florida an invitation to attend its Fourth Annual Meeting, September 12 and 13, at the General Oglethorpe Hotel in Savannah. There is no registration fee. The scientific sessions will run Friday afternoon, September 12, starting at 1:00 p.m., and throughout the day on Saturday, September 13.

The March 1952 issue of *Florida Libraries* carried an interesting discourse on the operation of the Florida State Board of Health Library, Jacksonville, by Miss Lora-Frances Davis, librarian. The Library, as all other departments of the State Board of Health, operates under the direction of the State Health Officer, Dr. Wilson T. Sowder.

The article carried an explanation of the arrangement with the Florida Medical Association whereby Journals received through exchange are bound and made available to the Association's membership.

Dr. A. Franklin Harrison of Madison, president of the Madison County Medical Society, was one of the principal speakers at the Farm and Home Institute, held at Camp Cherry Lake, near Madison, August 29. Dr. Harrison appeared on the program during the session on medicine and health.

The Florida Medical Association was invited by the Agricultural Extension Service of Florida State University and the University of Florida to participate in the Institute as part of its Rural Educational Program.

Dr. Richard M. Fleming of Miami, chairman of the department of surgery at Mount Sinai Hospital, is in Oak Ridge, Tenn., studying the technics of using radioisotopes in research. He is among 32 research workers enrolled in a four-week course conducted by the special training division of the Oak Ridge Institute of Nuclear Studies.

Drs. Saul Miller and John H. Tanous of Miami Beach attended the meeting of the Congress of Biochemists in Paris recently.

Dr. William C. Roberts of Panama City was one of the principal speakers recently at a closing session of the Farm and Home Institute at Camp Timpoochee. Dr. Roberts, who represented the Florida Medical Association, appeared during the session on medicine and health.

Dr. Albert D. Rood of Jacksonville announces the opening of his office for the general practice of medicine at 1186½ Edgewood Ave.

Physicians contributed $671,834 to the American Medical Education Foundation during the first six months of 1952. On July 31, the National Fund for Medical Education distributed grants amounting to $15,000 each for the 72 four-year medical schools and $7,500 each for the seven two-year schools.

A new series of radio transcriptions entitled, "The Heart of America" will be released September 15 by the A. M. A.'s Bureau of Health Education. Dramatizing various aspects of the heart and its diseases, the 13 programs in the series are summarized by outstanding cardiologists and related experts. The series was produced in cooperation with the American Heart Association. Platters will be available from the F. M. A. Bureau of Public Relations after September 15.

The twelfth annual meeting of the Gulf Coast Clinical Society will be held in the San Carlos Hotel, Pensacola, Thursday and Friday, October 16-17. Outstanding physician speakers from throughout the South and East have been scheduled on the program, according to Dr. Dale E. York, Pensacola, secretary-treasurer. A partial list of these speakers was carried in your July Journal. Any member desiring additional information relative to this meeting should contact Dr. York at 21½ East Wright Street, Pensacola.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

POSITION AVAILABLE: Executive Secretary, Florida Heart Association. Salary $5,500. Experienced in Community organization, Fund Raising, Health Education. Write Jere W. Annis, M.D., President, Box 1021, Lakeland.

FOR SALE: Spencer Microscope; binocular; inclined lens mounting; mechanical stage; practically new; perfect condition; case included. Write: JDM, 1708 Conway, Orlando, Fla.

WANTED: M.D. for general practice in Mulberry, Fla. Address all inquiries to the City Council, Mulberry, Fla.

COMPONENT SOCIETY NOTES

Bay

At a recent meeting of the Bay County Medical Society, Dr. J. Powell Adams of Panama City spoke on X-ray physics, describing historical advances, present-day equipment, and the new "Betatron" which he said holds a great promise for future developments in X-ray work. The meeting also heard a report on the Bay County Blood Bank after two and one-half years of operation, and Dr. William C. Roberts of Panama City reported on the recent meeting of the Florida Medical Association in Hollywood which he attended as a delegate.

Dade

At the regular August meeting of the Dade County Medical Association a symposium on "Early Invasive Carcinoma of the Cervix — Diagnosis and Treatment" was held. Dr. Howard H. Groskloss was moderator, and panel members included Drs. Carl H. Davis, Harold E. Davis and Maurice Lev.

Escambia

The Escambia County Medical Society has paid 100 per cent of state dues for 1952.

Franklin-Gulf

Dr. Photis J. Nichols, Apalachicola, has been elected secretary of the Franklin-Gulf County Medical Society to fill the unexpired term of Dr. William P. Blackmon.

Nassau

The Nassau County Medical Society has paid 100 per cent of their state dues for 1952.

Palm Beach

At a recent meeting of the Palm Beach County Medical Society, the group endorsed a proposed Diabetes Detection Survey to be held there. Members also approved a motion to aid the local Visiting Nurses Association in their activities. Dr. J. R. Neider of Delray Beach showed films on "Cataract Surgery."

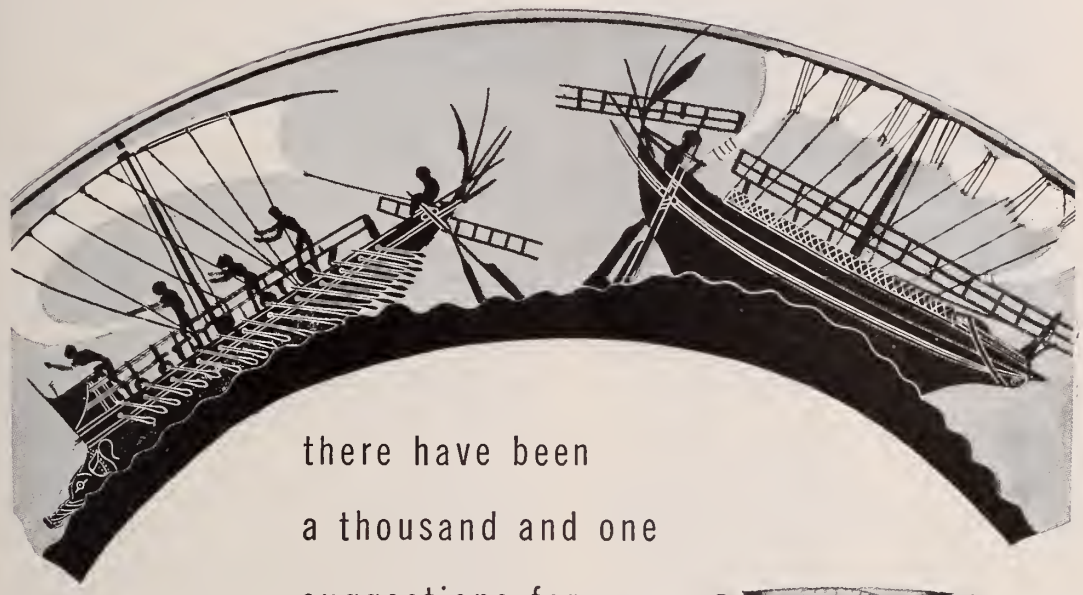
Sarasota

Thirty members of the Sarasota County Medical Society and their wives were guests of the Venice members for a tour of the Venice Memorial Hospital recently. A dinner dance and regular meeting of the Society was held in the evening at the Venice Yacht Club.

Walton-Okaloosa

The Walton-Okaloosa County Medical Society has paid 100 per cent of state dues.

Ever since man went down
to the sea in ships



there have been
a thousand and one
suggestions for
the relief of
motion sickness.

War ship and merchant ship, about 500 B. C.; from painted vase found at Vulci in Etruria, now in the British Museum.

Now, relief from this age-old malady with

DRAMAMINE®

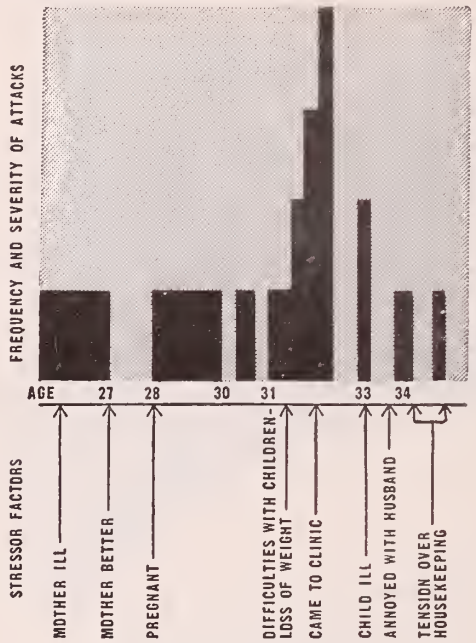
BRAND OF DIMENHYDRINATE

Available as: Tablets—50 mg.
Liquid—12.5 mg. per 4 cc.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Stress . . .

Stressor factors which evoke autonomic responses occur often in our civilization. They are not always of external origin, frequently, stress springs from the "well of uncertainties, the fears, the angers, and the hostilities that an inadequate childhood nurtures in troubled people in a troubled world." [1]



After: Relationship Between Life Stress And Symptoms — Stevenson, I.: G.P. 4: 67 (Dec.) 1951

When emotions aroused by these stresses are not dissipated in appropriate biological behavior, heightened autonomic impulses beat against a "moored" physique.[1]

Incessant "emotional buffeting" impinged on labile autonomic pathways is likely to produce deviations from normal body function and *a rash of symptoms*. In such cases, both branches of the autonomic nervous system are involved. For symptomatic relief oral administration of cholinergic and adrenergic blocking agents and central sedation has proven successful. Drugs effective for the several actions respectively are: belladonna alkaloids, ergotamine tartrate and phenobarbital. These drugs may be used individually or in combination,* as required by the individual case, to effect more stable function of the autonomic nervous system, thereby "dampening" overactivity of the involved organ systems.

* Dosage of each ingredient adjusted to the needs of the particular patient.

[1] *Cleghorn, R. A. and Graham, B. F.: Recent Progress in Hormone Research, Vol. IV, New York, Academic Press, Inc., 1949, p. 323.*

Sandoz Pharmaceuticals
DIVISION OF SANDOZ CHEMICAL WORKS, INC.
68 CHARLTON STREET, NEW YORK 14, N. Y.

OBITUARIES

James Albert Bradley

Dr. James Albert Bradley of St. Petersburg died on April 16, 1952, in his stateroom aboard the USS Silverstar at St. Thomas, V. I., while on a Caribbean cruise. He was 52 years of age and had been in ill health for a year or more, having recently sold his office and embarked on the cruise to regain his health.

A Floridian by birth, Dr. Bradley was a native of Jacksonville. He attended the public schools of Florence, S. C., and in 1925 received the B.S. degree in medicine from the University of North Carolina. Two years later he was awarded the M.D. degree by the University of Pennsylvania School of Medicine, and then served his internship at Philadelphia General Hospital. In 1929, he was chief resident physician at Babies' Hospital in Philadelphia and from there he went to Texas to become Associate Professor of Medicine in the University of Texas Faculty of Medicine at Galveston. Later, he served for a year as a medical missionary for the Lutheran Church in India, and upon his return became Assistant Professor of Medicine at Louisiana State University Medical Center in New Orleans. From 1932 to 1934 he was senior house physician at Charity Hospital of Louisiana in New Orleans.

In 1935, Dr. Bradley entered the private practice of medicine in Florence and remained there until 1939, when he located in St. Petersburg. He specialized in internal medicine. During World War II, he served two years in the United States Navy as a volunteer specialist in the Medical Corps, with the rank of lieutenant commander, and spent one year at the base hospital in Trinidad. Locally, he was a member of the Trinity Lutheran Church, the St. Petersburg Civitan Club, the Lakewood Country Club and the St. Petersburg Yacht Club. He was a member of the staff of Mound Park Hospital.

Dr. Bradley held membership in the Pinellas County Medical Society, the Florida Medical Association and the American Medical Association. He was a fellow of the American College of Physicians and was a diplomate of the American Board of Internal Medicine.

Surviving are two sons, Kent Bradley of St.

Petersburg and James L. Bradley, now attending Officers' Candidate School at Camp Jackson, S. C.; and three sisters, Mrs. Inez Williams and Mrs. Louise Harris, both of Florence, and Mrs. Mona Dunlap of Rock Hill, S. C.

Henry Elliott Parnell

Dr. Henry Elliott Parnell of Perrine died on April 20, 1952 in a Lake City hospital following injuries received in a fall from the porch at the home of relatives in the Huntsville community, where he was attending a family reunion. He was 70 years of age. Interment took place in the Huntsville Cemetery.

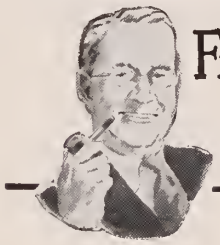
A native Floridian, Dr. Parnell was born in Columbia County on Dec. 24, 1881. He was the son of John Elliott and Rebecca Layton Parnell. After finishing high school, he taught school for several years before studying medicine. In 1908 he was graduated from the Kentucky School of Medicine in Louisville, Ky.

Returning to Florida, Dr. Parnell practiced medicine in Jasper until he entered the United States Army during World War I. As a major in the Medical Corps, he served 18 months at a base hospital in France. Following his discharge from military service, he practiced in Fort Myers and later was associated with the Collier interests in Everglades City, where he practiced and operated the Juliet Collier Hospital. The loss of his left forearm in a hunting accident in 1933 necessitated abandonment of his chosen field of surgery. He then turned to the practice of pediatrics and, later on, cardiology, in Miami, where he practiced until 1947. At the time of his death, he was actively engaged in the practice of medicine at Perrine.

Dr. Parnell was active in a number of medical organizations and particularly interested in post-graduate courses. He was a member of the Dade County Medical Association, the Florida Medical Association, the American Medical Association and the Southern Medical Association.

Survivors include the widow, Mrs. Ruby Hendry Parnell of Perrine; one daughter, Miss Sarah Rebekah Parnell, who had just returned from an overseas embassy post in Helsinki, Finland; one son, James Elliott Parnell of Miami; one sister, Mrs. R. H. Weaver of Lake Wales; one brother, J. C. Parnell of Lake City; and three grandchildren.

Advertisement



From where I sit
by Joe Marsh

If They're Wild, They Belong to Tik!

Saw Tik Anderson last week and was reminded of the first time I ever spoke to him. The missus had sent me out one Saturday afternoon to hunt for some blackberries.

I took a long hike and couldn't find any. Finally, I came to Tik's house along that low stretch east of the fork on River Road. "Hi there," I says, "any blackberries around here?"

Tik says, "There used to be—but I don't know much about things that grow wild." Later, I found how Tik supports his family by picking berries. Ever since that time, I've been like the rest of folks in town—respectful of his right not to tell where "his" berries grow.

From where I sit, respecting other folks' rights comes natural in our town . . . and in America for that matter! Whether it's a person's right to enjoy a temperate glass of beer or ale, or the right of a man to practice his profession without outside interference, it's all a big part of a real democracy!

Joe Marsh

Copyright, 1949, United States Brewers Foundation

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting September 22, October 6, October 20. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting October 20. Surgical Anatomy & Clinical Surgery, Two Weeks, starting September 22, November 3. Surgery of Colon & Rectum, One Week, starting September 15, October 20. Gallbladder Surgery, Ten Hours, starting October 20. Bronchoscopy, One Week, by appointment. General Surgery, One Week, starting October 6. General Surgery, Two Weeks, starting October 6. Breast & Thyroid Surgery, One Week, starting October 6. Esophageal Surgery, One Week, starting October 13. Thoracic Surgery, One Week, starting October 20. Fractures & Traumatic Surgery, Two Weeks, starting October 6.

GYNECOLOGY—Intensive Course, Two Weeks, starting October 20. Vaginal Approach to Pelvic Surgery, One Week, starting September 22, November 3.

OBSTETRICS—Intensive Course, Two Weeks, startnig September 29, November 3.

MEDICINE—Electrocardiography & Heart Disease, Two Weeks, starting September 22. Intensive General Course, Two Weeks, starting October 13. Gastroenterology. Two Weeks, starting October 27. Gastroscopy & Gastroenterology, Two Weeks, starting September 15, November 3.

CYSTOSCOPY—Ten-Day Practical Course starting every two weeks.

DERMATOLOGY Intensive Course, Two Weeks, starting October 13.

Teaching Faculty:

Attending Staff of Cook County Hospital

Address: Registrar, 707 South Wood Street

Chicago 12, Illinois

Specialized

LABORATORY SERVICES

Thyroid Activity
determined by
SERUM PROTEIN-BOUND IODINE
a reliable index to presence and course of

Hypo and Hyper Thyroidism
now available routinely.
(12 cc. clotted blood required)

FLAME PHOTOMETRY
A safeguard against

ELECTROLYTE IMBALANCE
by most reliable, rapid instrument.

SODIUM, POTASSIUM AND CALCIUM TESTS
(1.0 cc. serum each test — 24 hrs. service)

URINE 17 KETOSTEROIDS TESTS
Available soon — Micro method 25 cc. required

Containers, instructions and rates on request for physicians and hospitals.
Airmail — Special Delivery Suggested

Research **Consulting**

SHAW LABORATORIES

1923 14th Ave., So.
Birmingham, Alabama

Office Phone 4-4733 Night Phone 54-5960

WOMAN'S AUXILIARY
TO THE
FLORIDA MEDICAL ASSOCIATION
OFFICERS

MRS. HERSCHEL G. COLE, President.....*Tampa*
MRS. THOMAS C. KENASTON, President-elect.....*Cocoa*
MRS. RICHARD F. STOVER, 1st Vice Pres.....*Miami*
MRS. NELSON A. MURRAY, 2nd Vice Pres.....*Jacksonville*
MRS. REAVES A. WILSON, 3rd Vice Pres.....*Sarasota*
MRS. TAYLOR W. GRIFFIN, 4th Vice Pres.....*Quincy*
MRS. ALBERT G. LOVE, IV, Recording Sec'y.....*Gainesville*
MRS. HERBERT B. LOTT, Correspd. Sec'y.....*Tampa*
MRS. SAMUEL S. LOMBARDO, Treasurer.....*Jacksonville*

COMMITTEE CHAIRMEN

MRS. CHARLES F. HENLEY, Finance.....*Jacksonville*
MRS. EDWARD F. SHAVER, Today's Health.....*Tampa*
MRS. ALVIN L. MILLS, Legislation.....*St. Petersburg*
MRS. C. RUSSEL MORGAN, JR., Public Relations.....*Miami*
MRS. WILLIAM G. MERIWETHER, Reference.....*Plant City*
MRS. SHERREL D. PATTON, Civil Defense.....*Sarasota*
MRS. CARROLL V. HERRON, Projects.....*Daytona Beach*
MRS. JULIUS ALEXANDER, Program.....*Miami*
MRS. JAMES T. COOK, JR., Bulletin.....*Marianna*
MRS. GEORGE H. PUTNAM, Historian.....*Gainesville*
MRS. ANGUS D. GRACE, Parliamentarian.....*Fort Myers*
MRS. ALFONSO F. MASSARO, Revisions.....*Tampa*
MRS. JOHN E. MAINES, JR., Stu. Loan Fund....*Gainesville*
MRS. ARTHUR R. KNAUF, Medaux.....*Tampa*
MRS. CHARLES McD. HARRIS, JR., Study Group.....*W. P. Beach*
MRS. C. ROBERT DEARMAS, Auxiliary Writer for State Medical Journal.....*Daytona Beach*
MRS. EDWARD W. CULLIPHER, Stu. Nurse Recruit. *Miami*
MRS. LEFFIE M. CARLTON, JR., Hospitality.....*Tampa*

Organizational Boomerang

There is a growing tendency in civic organizations to judge the merits as well as the progress of a group by the size of its membership roster. This is dangerous because emphasis is placed on quantity and leaves us to assume that a person who joins a group believes in its principles. This is not necessarily so and is a risky assumption which can turn a well intentioned organization into a Frankenstein if the increase in membership takes precedence over the growth of the organization's ideals, which is its motivating reason for being.

If too much attention is devoted to how many members and not enough attention to what kind of members, many of whom assume the label of the organization with no loyalties nor interest in its aims, we may have a boomerang which can bludgeon a well intentioned people into becoming instruments for causes they would not knowingly support.

It is better to have no organization if the principles of a group become vague or are undefined in the minds of its members. It is better that people be hard to reach by the proponents of any idea than to be available in neat little organizational bundles with tags denoting their voting potential, to be picked at will to be used to further the ends of the astute leader who reaches it first.

Such organizations are not unlike herds of reindeer which, when led under capable leadership, can span the coldest and highest reaches in the area, but can be plunged over a precipice in a matter of minutes by a sudden and strategic howl of a coyote. This mass psychological device is used advantageously frequently to create confusion and to further the ends of devious ideology.

In the halcyon era of differentism, which security and plenty bred into the attitudes of many, we plodded along in complacent little herds obediently mushing along the path set by the leaders whose authority was established by virtue of achieved leadership. How achieved was not the concern of many. We followed the leader of whatever group we belonged.

It was not until the fires which raged in Europe and Asia began to nibble at our hedges, forcing us into a common clearing and into the frightening glare of chaos caused by men of irresponsible action, that we were driven by the instinct of self-preservation to think for ourselves; to examine the candidates for leadership and question the paths we are expected to follow. This cannot be done any longer by party affiliation. As in any crisis, be it neighborhood, nation or inter-nation, the burden of responsibility falls upon the individual.

We find ourselves at the crossroads of decision. The panic of impending disaster forces people into the security of a group activity seeking the right way, which is why the integrity and quality of a group should be of the highest standard.

During election time our comforting sign post "The American Way" is temporarily obscured by the detour sign, "road closed for repairs," which convention time necessitates. The barkers at the crossroads, impassioned pleaders all, beckon us to follow their directions. Each claims to have the safe transport of their people at heart. Each warns of the pitfalls on the other path. If we are to walk in confidence we must know not only for whom we vote but why we do so.

It is not enough to know what they want. We must know what we want. It is not enough to know what they think. We must know what we think.

Only then will our individual membership with the developed integrity honest effort creates be a contribution to any group. For it is the cumulative integrity of thinking individuals in any organization which justifies its existence and makes it a power house for the benefit of man instead of a land mine which might destroy his freedom.

Mrs. C. Robert DeArmas.

Ambulance Service

FERGUSON FUNERAL HOME
H. E. Ferguson, Licensed Director
1201 South Olive
WEST PALM BEACH, FLA.

MAC'S WALKERS

Made of light weight steel tubing (5lb.) Welded joints for strength and rigidity. Can't slip or turn. Safer than crutches. Stock sizes 32, 33, 34, 35, 36 inches. Give height of person when ordering. Children's and special sizes made to order. Price $11.00 delivered in Florida.

Made by
H. W. McCORD
2018 W. Fairbanks Avenue
WINTER PARK, FLORIDA

THE EARLE JOHNSON SANATORIUM

For the care of nervous, mental, senile, alcoholic, and addicted cases. **Moderate rates.**

Operated by C. Earle Johnson, Jr., M.D., Psychiatrist-in-Chief, F.A.P.A., F.A.C.P. Diplomate of the American Board of Psychiatry and Neurology.

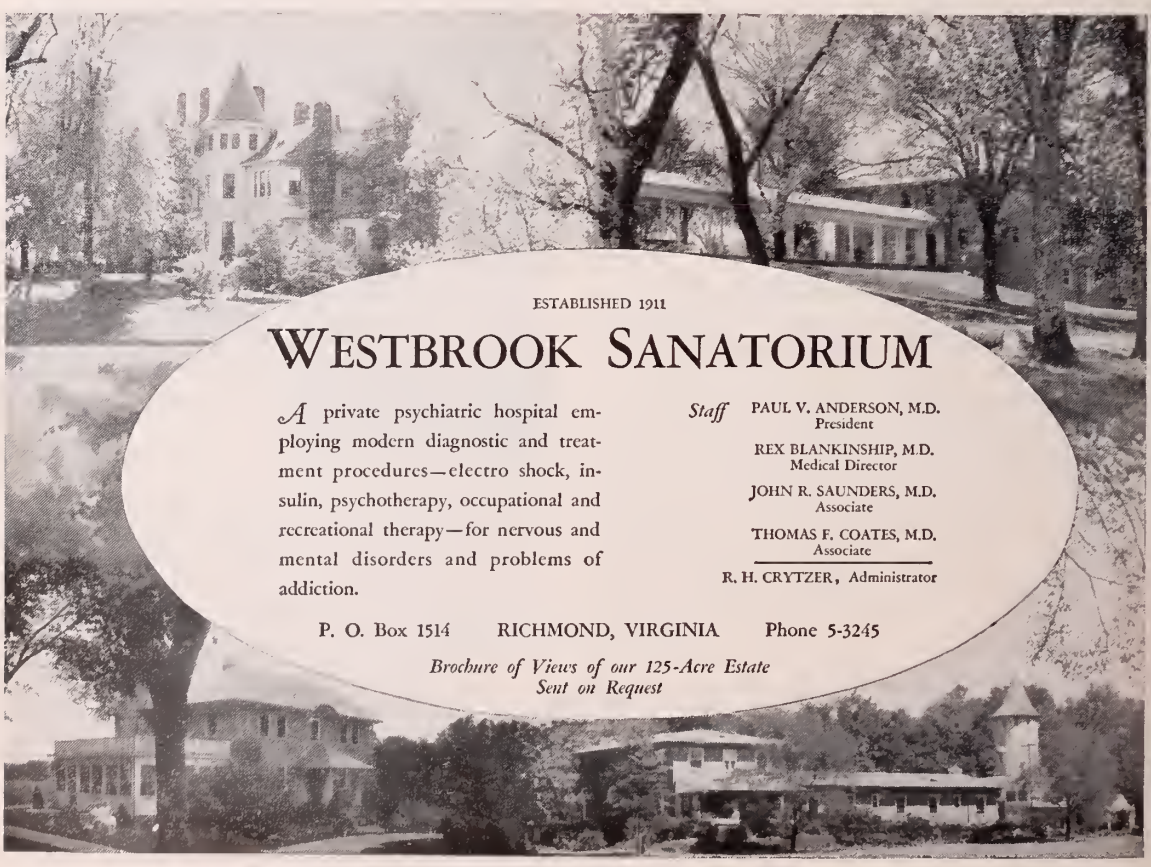
The most modern and effective psychiatric methods are employed. Gradual reduction in the addictions antabuse treatment for alcoholism.

Telephone: 3-3369 or 3-3360
Write: Drawer 106
Meridian, Mississippi

CONVENTION PRESS

218 WEST CHURCH STREET
JACKSONVILLE
FLORIDA

Commercial and Publication Printing



ESTABLISHED 1911

WESTBROOK SANATORIUM

A private psychiatric hospital employing modern diagnostic and treatment procedures—electro shock, insulin, psychotherapy, occupational and recreational therapy—for nervous and mental disorders and problems of addiction.

Staff
PAUL V. ANDERSON, M.D.
President
REX BLANKINSHIP, M.D.
Medical Director
JOHN R. SAUNDERS, M.D.
Associate
THOMAS F. COATES, M.D.
Associate
R. H. CRYTZER, Administrator

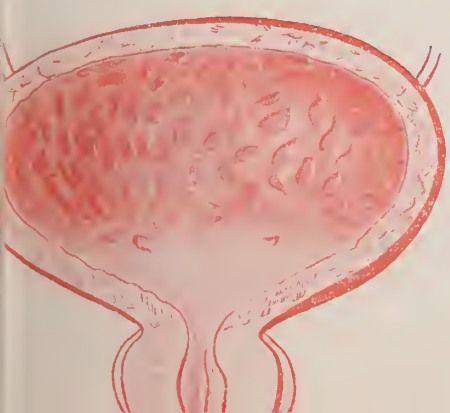
P. O. Box 1514 RICHMOND, VIRGINIA Phone 5-3245

Brochure of Views of our 125-Acre Estate Sent on Request

attain the goal in acute urinary tract infections– quickly...

The immediate goal in pyuria, regardless of etiology, is to render the urine sterile. SULAMYD,® (sulfacetamide—Schering) is a highly soluble sulfonamide, rapidly cleared from the blood stream and highly bacteriostatic for most common urinary tract pathogens. SULAMYD quickly controls infections with negligible risk of renal complications because of its ready solubility in urine.

SULAMYD



Schering CORPORATION
BLOOMFIELD, N. J.
IN CANADA: SCHERING CORPORATION, LTD., MONTREAL

SULAMYD

SCHERING

"Actually, it has not been so much a case of PENTOTHAL Sodium's supplanting other anesthetic agents and methods as it has been of complementing and supplementing them to the mutual advantage of one another."

Adams, R. Charles (1951), Intravenous Administration of Pentothal Sodium in Combination with Other Anesthetic Agents and Methods, J. Missouri Med. Assn., August.

IN minor and major surgery, for induction or induction and maintenance, *alone or in combination* with other anesthetics, PENTOTHAL Sodium continues to grow in popularity in operating rooms throughout the civilized world. Not without reason:

Eighteen years of experience, nearly 1900 published reports have shown that intravenous anesthesia with PENTOTHAL means a smooth, easy induction, generally without anxiety. And that deeper anesthesia may be had in a moment, as needed. Recovery is short, pleasant and usually without nausea. No bulky frightening equipment is needed. The fire and explosion hazard is eliminated. And, as it says above, this ultra-short-acting barbiturate complements and supplements other agents to "the mutual advantage of one another."

Abbott

FOR INTRAVENOUS ANESTHESIA

PENTOTHAL® Sodium

(STERILE THIOPENTAL SODIUM, ABBOTT)

Broad spectrum antibiotic therapy

NOW IN THE BEST OF TASTE

CRYSTALLINE
Terramycin
oral suspension
(flavored

Pfizer

Antibiotic Division
CHAS. PFIZER & CO., INC.
Brooklyn 6, N. Y.

world's largest producer of antibiotics

For the Failing Heart of Middle Life

Prescribe 2 or 3 tablets of Theocalcin, t. i. d. After relief is obtained, continue with smaller doses to keep the patient comfortable. Theocalcin strengthens heart action, diminishes dyspnea and reduces edema.

Brand of theobromine-calcium salicylate,
Trade Mark reg. U. S. Pat. Off.

Bilhuber-Knoll Corp. Orange, N. J.

MIAMI MEDICAL CENTER

P. L. DODGE, M.D.
Medical Director and President

1861 N. W. South River Drive
Phones 2-0243 — 9-1448

A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures — Psychotherapy, Insulin, Electroshock, Hydrotherapy, Diathermy and Physiotherapy when indicated. Adequate facilities for recreation and out-door activities. Cruising and fishing trips on hospital yacht.

Information on request
Member American Hospital Association

• In MIAMI SANITARIUM

Medical Hospital American Plan Hotel for Patients and their families. REST, CONVALESCENCE, ACUTE and CHRONIC MEDICAL CASES. Elderly People and Invalids. ***FREE Booklet!***

Acres Tropical Grounds, Delicious Meals, Res. Physician, Grad. Nurses, Dietitian.

SUN-RAY PARK HEALTH RESORT

Mild Mental Cases, Drug and Alcoholics in Separate Building

PROOF WITH ONE PUFF?

So distinct is the difference between PHILIP MORRIS and *any* other leading brand, that we believe you will notice it with a single puff. Won't you try this simple test, Doctor, and see?

Take a PHILIP MORRIS and any other cigarette

1. Light up either one first. Take a puff—get a good mouthful of smoke—and s-l-o-w-l-y let the smoke come directly through your nose.
2. Now, do exactly the same thing with the other cigarette.

You will notice a distinct difference between PHILIP MORRIS and any other leading brand.

PHILIP MORRIS

Philip Morris & Co., Ltd., Inc., 100 Park Avenue, New York 17, N. Y.

The Right to *Choose* . . . .

CORNERSTONE OF AMERICAN LIBERTY

Hospital Expense Plans

Medical-Surgical Expense Plans

Paycheck Protection Plans

Life Insurance Plan

AS long as Americans keep the right to choose — their church, their political party, their doctor and their hospital — freedom must prevail.

We are proud that hundreds of thousands of Americans have freely chosen the protection afforded them by PENNSYLVANIA LIFE'S liberal, low-cost health insurance plan.

Pennsylvania Life
HEALTH & ACCIDENT **Insurance Company**

FOUNDED 1890

HOME OFFICE: PHILADELPHIA 5, PA.

19 District Offices in Florida

Miami	Executive Office 3028 Biscayne Blvd.	Fort Lauderdale	521½ South Andrews Avenue
	Downtown 1210 Pacific Building	Jacksonville	303 Clark Building
	Southwest 1260 S. W. 22nd Street	Tampa	228 Cass Street Arcade Building
	Little River 8340 N.E. Second Ave., Suite 245	Sarasota	237 Main Street, Room 15
	Coral Gables 3028 Biscayne Blvd.	Fort Pierce	Florida Bank Building, Room 34
	Miami Beach 206 Harvey Building	Daytona Beach	116½ Orange Avenue
St. Petersburg	509 White Building	Tallahassee	429 Centennial Building
Lakeland	206 Marble Arcade	Panama City	142 Harrison Avenue
West Palm Beach	305 Citizens Building	Pensacola	501 Theisen Building
Orlando	209 Slayton Building		

"Now may I—

—call the MEDICAL SUPPLY MAN?"

Never seen a sterilizer make ice? Well, frankly, neither have we! But things do go wrong with complicated equipment and that's where the Medical Supply Man can be of real help to you. He always knows exactly what to do no matter what happens.

But repair work is only one of his specialties! Take the matter of supplies for instance. Ordinarily the Medical Supply Company has more than 15,000 individual items in stock at all times. When you call the Medical Supply Man you get what you want in a hurry!

So, anytime you think of supplies, new equipment or expert repair service, always obey that impulse and CALL THE MEDICAL SUPPLY MAN!

HOSPITAL, PHYSICIANS and LABORATORY SUPPLIES & EQUIPMENT

MEDICAL SUPPLY COMPANY

Essentials For Scientific Progress

MIAMI • of JACKSONVILLE • ORLANDO

230 N. E. THIRD ST.
MIAMI 32, FLA.

420 WEST MONROE ST.
JACKSONVILLE 2, FLA.

329 N. ORANGE AVE.
ORLANDO, FLA.

One of America's Fine Institutions . . .

Newdigate M. Owensby, M.D.
Psychiatrist-in-Chief
Specialist Certified by the American Board of Psychiatry and Neurology

Willis T. McCurdy, M.D.
Attending Physician

J. Rufus Evans, M.D.
Attending Physician

Elizabeth Hancock
Psycho-Therapist

Atlanta Office,
384 Peachtree Street

Dedicated to the Scientific Treatment of Nervous and Mental Disorders . . .
. . . In a setting of Inviting Friendliness and Simple Grace . . . Elevation 1200 Feet

BROOK HAVEN MANOR SANITARIUM

STONE MOUNTAIN, GA.

HILL CREST SANITARIUM

FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

Thoroughly modern in architecture and construction. Eight departments — affording proper classification of patients. All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

James A. Becton, M.D., Physician-in-charge — James Keene Ward, M.D., Associate Physician

P. O. Box 2896, Woodlawn Station, Birmingham, Alabama — **Phones 9-1151 and 9-1152**

BRAWNER'S SANITARIUM

Established 1910

SMYRNA, GEORGIA
(Suburb of Atlanta)

For Nervous and Mental Disorders
Drug and Alcohol Addiction
Electro-Shock in selected cases

JAMES N. BRAWNER, M.D., Medical Director
ALBERT F. BRAWNER, M.D., Department for Men
JAMES N. BRAWNER, JR., M.D., Department for Women

Allen's Invalid Home

MILLEDGEVILLE, GA.

Established 1890
For the treatment of
NERVOUS AND MENTAL DISEASES

Grounds 600 Acres
Buildings Brick Fireproof
Comfortable Convenient
Site High and Healthful

E. W. Allen, M.D., *Department for Men*
H. D. Allen, M.D., *Department for Women*
Terms Reasonable

S. A. Kyle *Funeral Director*

MEMBER National Selected Morticians BY INVITATION

17 WEST UNION STREET
JACKSONVILLE 2, FLORIDA
Phones 5-3766 5-3767

BISCAYNE HOSPITAL

6339 Biscayne Blvd.
MIAMI 38, FLORIDA

Members of the Dade County Medical Association are acquainted with the high type of service rendered.

David Collins, Superintendent

Registered, American Medical Association
Phone 7-4544

MIAMI RETREAT SANATORIUM

FOUNDED 1927

For Nervous and Mental Disorders, Alcohol and Drug Addiction

STAFF OF EIGHT NEUROPSYCHIATRISTS
New X-Ray Diagnostic Treatment Facilities
Comfortable AIR-CONDITIONED rooms, suites

79TH STREET AT MIAMI AVENUE
MIAMI 38, FLORIDA

Phone 7-1824

TUCKER HOSPITAL, INC.

212 West Franklin Street

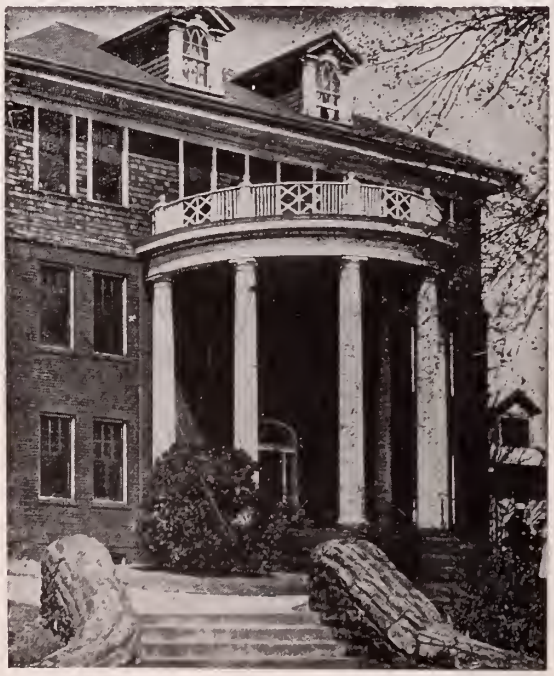
RICHMOND, VIRGINIA

A private hospital accepting for diagnosis and treatment organic neurological conditions, selected psychiatric and alcoholic cases, metabolic disturbances of an endocrine nature, individuals who are having difficulty with their personality adjustments, and children with behavior problems. Patients with general medical disorders admitted for treatment under our staff of visiting physicians.

Under the Professional Charge of

DR. HOWARD R. MASTERS,
DR. JAMES ASA SHIELD AND ASSOCIATES

HIGHLAND HOSPITAL, INC.



FOUNDED IN 1904

Asheville, North Carolina

AFFILIATED WITH DUKE UNIVERSITY

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a sixty-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D.,
Diplomate in Psychiatry
Medical Director

ROBT. L. CRAIG, M.D.,
Diplomate in Neurology and Psychiatry
Associate Director

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Medical Association	Robert B. McIver, Jacksonville	Samuel M. Day, Jacksonville	Hollywood, Apr. 26-29, '53
Medical Districts	Eugene G. Peek, Jr., Ocala	Council Chairman	
rthwest	Francis M. Watson, Marianna	Benjamin A. Wilkinson, Tallahassee	Panama City, Oct. 27, '52
rtheast	William C. Thomas, Jr., Gainesville	Eugene L. Jewett, Orlando	Daytona Beach, Oct. 31, '52
uthwest	Emmett E. Martin, Haines City	Hugh G. Reaves, Sarasota	St. Petersburg, Oct. 29, '52
utheast	Erasmus B. Hardee, Vero Beach	Donald W. Smith, Miami	Ft. Pierce, Oct. 30, '52
Specialty Societies			
y of General Practice	Edward F. Shaver, Tampa	Frank T. Linz, Tampa	Hollywood, Apr. 26, '53
Society	Nelson Zivitz, Miami Beach	Solomon D. Klotz, Orlando	" "
siologists, Soc. of	John T. Stage, Jacksonville	Breckenridge W. Wing, Orlando	" "
, Am. Coll. Chest Phys	Alexander Libow, Miami Beach	DeWitt C. Daughtry, Miami	"
nd Syph., Soc. of	Lewis Capland, Miami Beach	Morris Waisman, Tampa	" "
Officers' Society	George W. Edwards, II, Orlando	Lorenzo L. Parks, Jacksonville	" "
ial & Railway Surgeons	John H. Mitchell, Jacksonville	William H. Chapman, Jacksonville	" "
gy & Psychiatry	W. Tracy Haverfield, Miami	Roger E. Phillips, Orlando	" "
l Gynec. Society	Dorothy D. Brame, Orlando	J. Champneys Taylor, Jacksonville	" "
l & Otol., Soc. of	Joseph W. Taylor, Sr., Tampa	Carl S. McLemore, Orlando	" "
dic Society	Arthur H. Weiland, Coral Gables	Edward W. Cullipher, Miami	" "
gists, Society of	Robert J. Poppiti, Miami Beach	Alfred E. Cronkite, Fort Lauderdale	" "
c Society	Egbert V. Anderson, Pensacola	J. K. David, Jr., Jacksonville	W. Palm Beach, Nov. 8-9, '52
gic Society	Alex. E. Rosenberg, Miami Bch.	George Williams, Jr., Miami	Hollywood, Apr. 26, '53
gical Society	Thomas H. Lipscomb, Jacksonville	A. Judson Graves, Jacksonville	" "
cal Society	George H. Putnam, Gainesville	David W. Goddard, Daytona Beach	" "
—			
Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Oct. 25, '52
l Banks, Association	Donald W. Smith, Miami	Mr. J. M. Potts, Miami	
Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Daytona Beach, Nov. 16, '52
Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Mother Loretto Mary, Tampa	Hollywood, Apr. 26, '53
er Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	
al Society, State	W. G. McLeod, D.D.S., Pensacola	Coleman Brown, D.D.S., Tampa	St. Petersburg, Apr. 20-23, '53
Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
ital Association	Mother Loretto Mary, Tampa	Tracy B. Hare, Miami	Daytona Bch., Nov. 17-19, '52
cal Examining Board	Ralph B. Spires, DeFuniak Springs	Homer L. Pearson, Jr., Miami	Jacksonville, Nov. 23-25, '52
cal Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
es Association, State	Miss Undine Sams, Miami	Bertha King, Tampa	St. Petersburg, Nov. 14-16, '52
naceutical Association, State	Mr. Clyde Morris, Daytona Beach	Mr. R. Q. Richards, Ft. Myers	St. Petersburg, May, '53
c Health Association	Mrs. May Pynchon, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Jacksonville, Oct. 9-11, '52
rculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Elsa B. Conant, Pt. St. Joe	
an's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	Hollywood, Apr. 26-28, '53
an Medical Association	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	New York, June 1-5, '53
A. Clinical Session	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	Denver, Dec. 2-5, '52
n Medical Association	R. J. Wilkinson, Huntington, W. Va	Mr. C. P. Loranz, Birmingham	Miami, Nov. 10-13, '52
a Medical Association	B. W. McNease, Fayette	Douglas L. Cannon, Montgomery	Birmingham, Apr. 16-18, '53
, Medical Assn. of	C. F. Holton, Savannah	Mr. Sid Wrightsman, Atlanta	Savannah, May 10-13, '53
Iospital Conference	Mr. Norman Losh, Orlando	Mr. D. O. McClusky, Tuscal'sa, Ala.	New Orleans, April 8-10, '53
stern Allergy Assn.	Clarence Thomas, Nashville, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Havana, Cuba, Mar. 26-29, '53
stern, Am. Urological Assn.	William Miner, Covington, Ky.	Sidney Smith, Raleigh, N. C.	Nashville, May, '53
stern Surgical Congress	H. L. Claud, Washington, D. C.	B. T. Beasley, Atlanta	Louisville, Mar. 9-12, '53
oast Clinical Society	Alvin L. Stebbins, Pensacola	Dale E. York, Pensacola	Pensacola, Oct. 16-17, '52

Janet's Nursery for Babies
P. O. Box 191
OSPREY, FLORIDA
Phone RIngling 4-1647

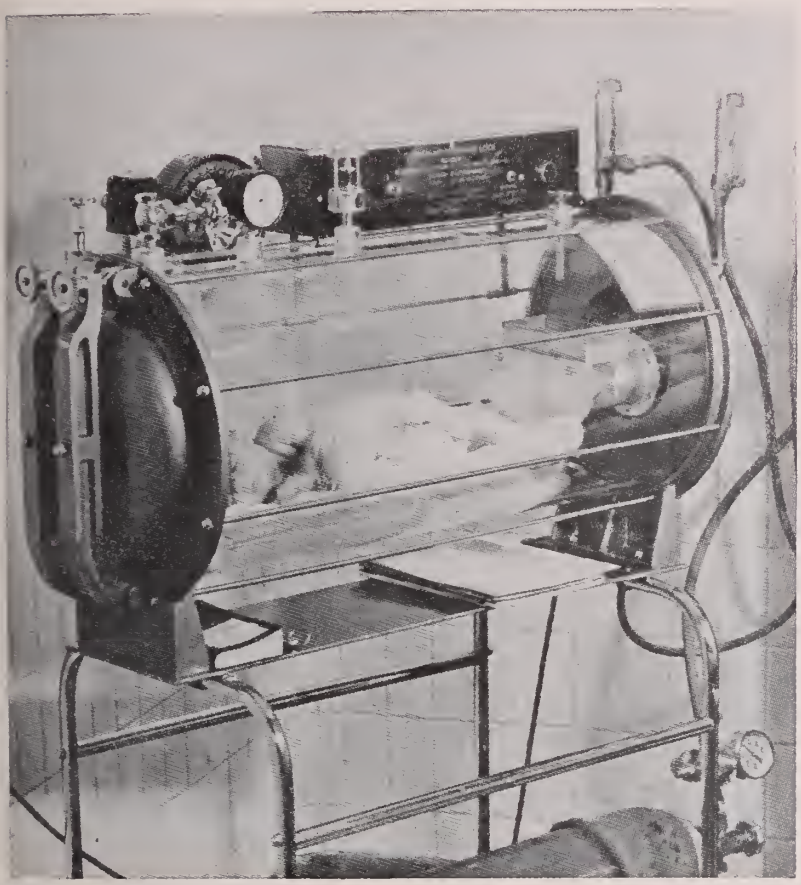
A Nursery for Handicapped Babies

For Information write
H. KEITH JACOBUS
P. O. Box 191
Osprey, Florida

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS Total	MEMBERS Paid	COUNCILOR
A	Bay	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	William F. Humphreys, Jr., M.D. 112 E. 3rd Court Panama City		24	100%	
	Escambia *Santa Rosa*	Chas. J. Heinberg, M.D. 109 N. Baylen St. Pensacola	Raymond B. Squires, M.D. 386 Brent Bldg. Pensacola	2nd Tuesday 8:00 P.M.	76	100%	
	Franklin-Gulf	John W. Hendrix, M.D. Port St. Joe	Photis J. Nichols, M.D. Apalachicola	Last Wednesday	8	100%	A-1-54 Francis M. Watson, M.D. Marianna
	Jackson-Calhoun	Albert E. McQuagge, M.D. 207 N. Green St. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	16	
	Walton-Okaloosa	William D. Cawthon, M.D. DeFuniak Springs	Edgar H. Myers, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	100%	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		5	100%	
	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	100%	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	Ernest W. Ekermeyer, M.D. 516 N. Adams St. Tallahassee	George H. Massey, M.D. 204 N. Madison St. Quincy	Quarterly 7:30 P.M.	58	53	
	Suwannee	Edward G. Haskell, Jr., M.D. Branford	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak	1st Saturday 9:30 A.M.	8	100%	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Madison	A. Franklin Harrison, M.D. Madison	Eugene D. Thorpe, M.D. Madison		3	100%	
	Taylor *Dixie, Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	3	100%	232
B	Alachua *Bradford, Gilchrist, Union*	Henry J. Babers, Jr., M.D. Box 709 Gainesville	Raymond S. Camp, M.D. 907 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	49	48	
	Duval *Clay*	Ferdinand Richards, M.D. 508 Greenleaf Bldg. Jacksonville	Joseph A. J. Farrington, M.D. 415 Greenleaf Bldg. Jacksonville	1st Tuesday 8:15 P.M.	255	240	
	Marion *Levy*	Carl S. Lytle, M.D. 1206 E. Ocklawaha Ave. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	30	26	B-3-54 William C. Thomas, Jr., M.D. Gainesville
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	11	100%	
	Putnam	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	Bennie J. Massey, M.D. Box 105 Palatka	2nd Tuesday 6:00 P.M.	10	9	
	St. Johns	Charles C. Grace, M.D. 145 King St. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
	Brevard	James A. Sewell, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	23	21	
	Lake *Sumter*	Robert H. Montgomery, M.D. Mount Dora	J. Basil Hall, M.D. Mount Dora	1st Wednesday 7:30 P.M.	26	25	B-4-53 Eugene L. Jewett, M.D. Orlando
	Orange *Osceola*	Carl S. McLemore, M.D. 1217 Kuhl Ave. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	154	147	
	Seminole	Julian N. Tolar, M.D. First Street Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	16	100%	
	Volusia *Flagler*	J. Richard West, M.D. 224 S. Palmetto Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	79	78	668
C	Hillsborough	Sherman B. Forbes, M.D. 409 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	173	154	
	Manatee	John E. Granade, M.D. 114 Walcaid Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	19	17	
	Pasco-Hernando- Citrus	William H. Walters, Jr., M.D. Lacoochee	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	16	100%	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Pinellas	John P. Rowell, M.D. 2500 Driftwood Rd., S. E. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Mon. Even Mo. 1st Fri. Odd Mo. 6:00 P.M.	190	186	
	Sarasota	Henry G. Morton, M.D. 555 Golf St. Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	2nd Tuesday 8:30 P.M.	44	100%	
	DeSoto-Hardee- Highlands- Glades	Harold S. Agnew, M.D. 705 E. Oak St. Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	26	23	
	Lee-Charlotte- Collier-Hendry	John S. Stewart, M.D. Lee Memorial Hosp. Fort Myers	Harvie J. Stipe, M.D. 210 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	24	23	C-6-54 Emmett E. Martin, M.D. Haines City
	Polk	Ivan W. Gessler, M.D. 402 Professional Bldg. Winter Haven	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	93	90	585
D	Indian River	P. T. McClellan, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	6	
	Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Drive West Palm Beach	David A. Newman, M.D. 511 Citizens Bldg. West Palm Beach	3rd Monday 8:00 P.M.	117	116	D-7-54 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie- Okeechobee- Martin	Richard F. Sinnott, M.D. 209 Koblegard Bldg. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	15	13	
	Broward	Lloyd U. Lumpkin, M.D. 918 E. Las Olas Blvd. Ft. Lauderdale	William K. Peck, M.D. 915 N. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	82	78	
	Dade	Ralph S. Sappenfield, M.D. 630 duPont Bldg. Miami	Nelson Zivitz, M.D. 311 Lincoln Rd. Miami Beach	1st Tuesday 8:30 P.M.	613	572	D-8-53 Donald W. Smith, M.D. Miami
	Monroe	James B. Parramore, M.D. Box 326 Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	13	12	847

*Suspense and aid until organized separately. Total 2,33

WHAT'S ABSOLUTELY NEW?



The Bloxsom-Airlock is Widely Acclaimed.

We Quote from an Editorial in Sept. Issue of WESTERN JOURNAL OF SURGERY, OBSTETRICS AND GYNECOLOGY: —

IMMEDIATE INFANT SURVIVAL

It would seem that . . . this observer must comment most favorably upon the new infant respirator devised by Bloxsom called the "positive-pressure air lock."

Bloxsom . . . has devised a positive air lock mechanism which repeats the cycles of pressures and timing found within the uterus itself. . . .

Speaking after a period of careful and critical observation, the writer has developed a peace of mind about the newborn infant which is most grateful. All infants are placed routinely within the air lock after delivery —

. . . No effort is made to resuscitate the infant as such but instead it is quickly transferred from mother to mechanical mother. . . . Some infants must stay in the air lock a period of only a few minutes and then may be removed to the regular neonatal nursery. Other infants may stay a matter of some days with complete security. Bloxsom's preliminary figures on the increased survival of premature infants have been most encouraging. . . . We cannot help but comment on what to us seems to be a definite improvement in the neonatal life period of our future citizens.

Write us for further details

MEMBER

AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A. Quality and Service

Anderson Surgical Supply Co.

Established 1916

Telephone 5-8391
40-42 W. DUVAL STREET
P. O. Box 1799
JACKSONVILLE 1, FLORIDA

Telephone 2-8504
1101-1105 TAMPA STREET
P. O. Box 1228
TAMPA 1, FLORIDA

Telephone 7-4589
21 3rd STREET N.
ST. PETERSBURG, FLORIDA

NEW YORK ACADEMY OF MEDICINE
2 E 103RD ST
NEW YORK N Y 29

J C-E

Magnifies the rays of the sun...

...dispels the shadow of Rickets

Even in America today, surveys of certain groups reveal a surprising incidence of rickets.

To combat this danger, physicians realize the need for *regular* and *reliable* antirachitic measures.

A potent and economical source of vitamins A and D, Mead's Oleum Percomorphum has provided effective protection for millions of infants and children. For 17 years, physicians have placed faith in it.

Local Representative: Roger J. McElroy, 3181 McDonald Street, Coconut Grove 33, Florida, 4-4124.

The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXIX OCTOBER, 1952 No. 4

IN THIS ISSUE

Dermatologic Dangers of Sunlight
Morris Waisman

Exchange Transfusion in Erythroblastosis Fetalis
James J. Griffitts

Acute Craniocerebral Injuries
James G. Lyerly

"Coronary Disease" of Inner Ear
Jerome A. Hilger

Program Medical District Meetings
October 27-31, 1952

OF MEDICINE
OCT 13 1952
LIBRARY

OFFICIAL PUBLICATION OF THE
FLORIDA MEDICAL ASSOCIATION

toward a fuller life for epileptics

DILANTIN

DILANTIN Sodium (diphenylhydantoin sodium, Parke-Davis) is supplied in Kapseals® of 0.03 Gm. (½ gr.) and 0.1 Gm. (1½ gr.) in bottles of 100 and 1000.

One university has recently graduated sixteen epileptics from its regular courses.[1] Two have received their Doctor of Philosophy degrees, and three have received their Master of Arts degrees. One is now an assistant professor, another has his own business, and all are gainfully employed.

DILANTIN, termed by many authorities a "drug of choice"[2-5] in *grand mal* and psychomotor seizures, is one of the agents chiefly responsible for such admirable results. Maximum success with DILANTIN is obtained with carefully individualized dosage schedules.

1. Michael, N.: Ohio State M. J. *48*:42, 1952.
2. Carter, S., in Conn, H. F.: Current Therapy 1952, Philadelphia, W. B. Saunders Company, p. 610.
3. Lennox, W. G., in Cecil, R. L., and Loeb, R. F.: A Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Company, 1951, p. 1379.
4. Lennox, W. G., in Piersol, G. M., and Bortz, E. L.: The Cyclopedia of Medicine, Philadelphia, F. A. Davis Company, 1951, Vol. V, p. 215.
5. Christian, H. A.. The Principles and Practice of Medicine, ed. 16, New York, D. Appleton-Century Company, 1947, p. 1370.

MEDICAMENTA VERA

Parke, Davis & Company

DETROIT, MICHIGAN

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

Volume XXXIX OCTOBER, 1952 No. 4

CONTENTS

SCIENTIFIC ARTICLES

The Dermatologic Dangers of Sunlight, Morris Waisman, M.D. 249
Exchange Transfusion in Erythroblastosis Fetalis, James J. Griffitts, M.D. 259
Acute Craniocerebral Injuries, James G. Lyerly, M.D. 264
"Coronary Disease" of the Inner Ear: The Vascular Origin of Vertigo and Deafness, Jerome A. Hilger, M.D. 269

EDITORIALS AND COMMENTARIES

Quo Vadis 275
Civil Defense Medical Supplies 276
Quiet for Heart Patient 277
Reports on Poisoning Sought 277
ILO — Danger Ahead! 278
Southeastern States Cancer Seminar, Tampa, Oct. 30-Nov. 1 278
Postgraduate Assembly in Endocrinology, Miami Beach, November 3-8 279
Southern Medical Association Meeting, Miami, November 10-13 279
Medical District Meetings 280
Dr. Bauer, A.M.A. President, Addresses Florida Medical Committee for Better Government 281

GENERAL FEATURES

Officers and Committees 272
From Our President 274
State Board of Health 284
Births, Marriages and Deaths 284
State News Items 285
Wanted — For Sale 286
New Members 286
Component Society Notes 286
Obituaries 287
Medical Licenses Granted 291
Schedule of Meetings 305
List of County Medical Societies, Presidents and Secretaries 306

This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

Announcing

A new film in full color

Special Problems in the Management
of
PEPTIC ULCER •
by
Department of Gastroenterology
of the Lahey Clinic

A Unit of the Wyeth Peptic Ulcer Service

Among the topics developed are: esophageal ulcer; gastric ulcer, benign and malignant; postbulbar ulcer and subtotal gastrectomy for intractable ulcer in the descending portion of the duodenum; pyloric obstruction; hemorrhage; postoperative jejunal or anastomotic ulcer. 16 mm., color with sound, 30 minutes. To obtain this film for group showing, write to:

FILM LIBRARY
WYETH INCORPORATED
1401 Walnut Street
Philadelphia 2, Pa.

- *FILMS*
- *LITERATURE*
- *MEDICATION*

Wyeth®

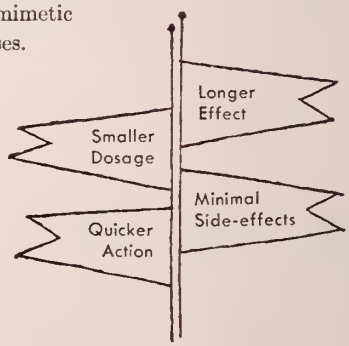
WYETH PEPTIC ULCER MEDICATION

Amphojel®, N.N.R. (Aluminum Hydroxide Gel, Alumina Gel)—For the medical management of gastric and duodenal ulcer; or for the control of symptomatic gastric hyperacidity.
Amphojel without Flavor, N.N.R.
Amphojel Tablets N.N.R. (Dried Aluminum Hydroxide Gel, Hydrated Alumina Tablets, 0.3 Gm. (5 grains); 0.6 Gm. (10 grains).
Phosphaljel®, N.N.R. (Aluminum Phosphate Gel)—for marginal ulcer.

HERE'S a tip: DESOXYN Hydrochloride will make the dieting patient a better bet than before by curbing his appetite and elevating his spirits. More potent than other sympathomimetic amines, DESOXYN produces the desired anorexia with smaller doses. Only one 2.5-mg. or 5-mg. tablet before breakfast and another an hour before lunch are usually sufficient.

In recommended doses, DESOXYN has quicker action, longer effect and a low incidence of side-effects. It is also effective as an adjunct in depressive states accompanying menopause, extended illness and convalescence, and in the treatment of alcoholism and narcolepsy.

Available at all pharmacies in 2.5-mg. and 5-mg. tablets, elixir and 1-cc. ampoules. Abbott



Desoxyn® hydrochloride

(Methamphetamine Hydrochloride, Abbott)

We Take Pride in Announcing

THE MOVING OF OUR OFFICES TO OUR OWN NEW BUILDING

As a result of the ever increasing acceptance and use of our products and reflecting the growth of our organization throughout the State of Florida we have moved into our new completely air-conditioned building. We respectfully extend a cordial invitation to the Medical Profession to visit our new home.

THE CHANGING OF OUR NAME TO KEY CORPORATION (Formerly Bever Corporation)

It is our sincere purpose and intention to make KEY CORPORATION a name which will be synonymous with the finest of quality, the newest and latest in drug therapies, and fair and reasonable prescription costs to your patient.

KEY CORPORATION

ETHICAL PHARMACEUTICALS

300 NORTH EAST 59th STREET
MIAMI, FLORIDA

Formerly Bever Corporation

"PREMARIN" ®

Highly effective • Well tolerated • Imparts a feeling of well-being

"PREMARIN"

The menopausal patient
welcomes the sense of well-being
imparted by "Premarin."

"PREMARIN"

Estrogenic Substances (water-soluble)

"PREMARIN"

also known as Conjugated Estrogens (equine)

"PREMARIN"

5209

AYERST, McKENNA & HARRISON Limited • New York, N. Y. • Montreal, Canada

Schering

CORTOGEN®

ACETATE

for

CORTISONE

therapy

CORTOGEN

The name Schering has come to stand for pioneering research and leadership in steroid hormone chemistry. Now Schering adds this new important product to its steroid line—available in ample amount to meet all your cortisone needs.

Available as 25 mg. tablets, bottles of 30. For complete information write to our Medical Service Department.

Schering CORPORATION · BLOOMFIELD, N. J.

what are *you* doing about DIABETES DETECTION?

This year's Diabetes Detection Drive will begin with Diabetes Week, November 16-22.

By joining, or helping to form, a Committee on Diabetes of your Medical Society, you can cooperate in the organized program to find unknown diabetics in your community.

As an individual practitioner, you can take an active—and essential—part in diabetes detection *all year round,* by making a test for urine-sugar routine for each and every patient.

P.S. It is only too easy for a busy doctor to overlook testing himself and members of his family.

To screen for diabetes, the simplest method is testing for urine-sugar. A test is made of the first specimen voided one to three hours—preferably 90 minutes—after a full meal. Positive findings of glycosuria are checked by blood-sugar determinations.

During the Diabetes Detection Drive, *Clinitest* Reagent Tablets are available to your Medical Society without charge when requested from the American Diabetes Association. For information call or write the Secretary of your Society.

for urine-sugar

CLINITEST
BRAND • REG. U. S. PAT. OFF. REAGENT TABLETS

AMES COMPANY, INC. ELKHART, INDIANA

AMES COMPANY OF CANADA, LTD., TORONTO

43152

You'll get a lot more out of the *all-new* GE Inductotherm

Now you can give your patients the desired quality and intensity for the full range of diathermy treatments. New GE Model F Inductotherm combines all the latest advances in induction heating therapy.

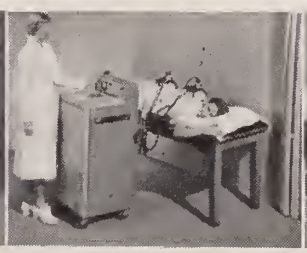
As shown in the pictures below, this handsome, trouble-free unit provides for a wide range of diathermy technics. Output has been raised to 200 watts — for most efficient utilization of induction heating methods. Unit is crystal controlled for absolute adherence to FCC-approved frequency.

Demand for the Model F is already great. To insure getting one of these great new Inductotherm units soon, call your GE x-ray representative right away. For illustrated literature, write

GENERAL ELECTRIC

Fully adjustable contour following electrode is part of the basic unit.

Optional is the 12 ft. treatment cable. Note how electrodes attach in rear.

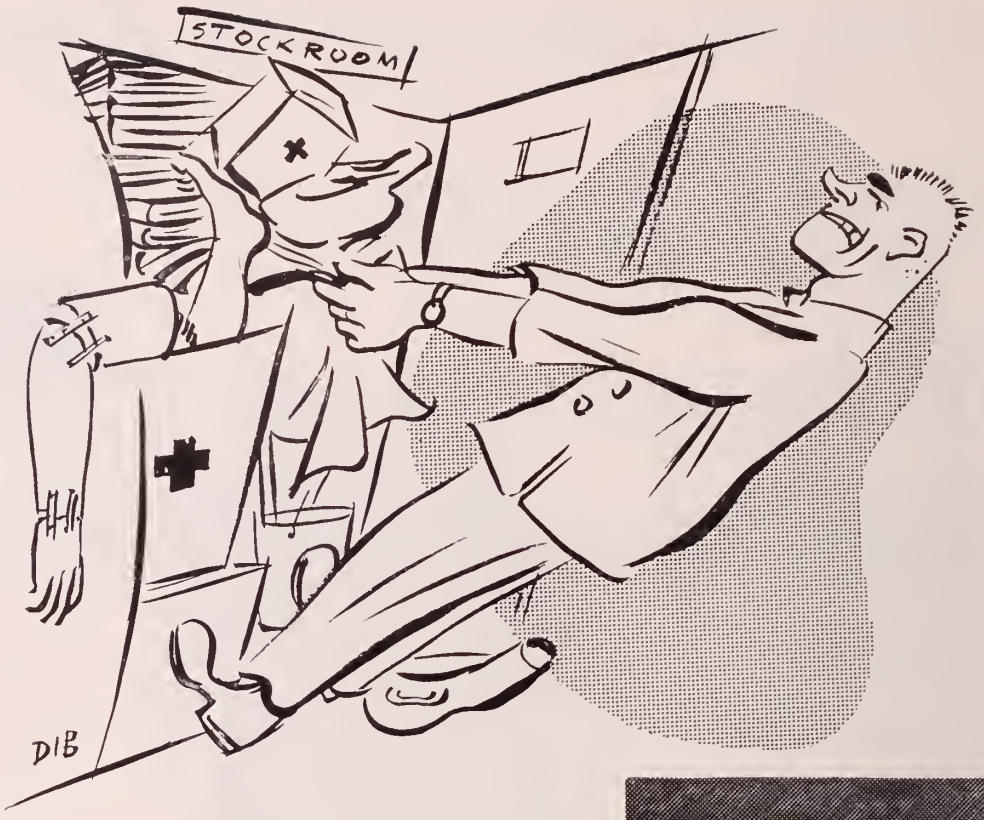


Also available: fully adjustable air-spaced condensor type electrode.

Surgical facilities, integral part of unit, for all medium and light technics.

Direct Factory Branches:

JACKSONVILLE — 210 W. Eighth St.
TAMPA — 1009 West Platt St.
MIAMI — 704 S.W. 27th Ave.
BIRMINGHAM — 707 21st St., South



". . . six, seven, eight, nine, ten — NURSE!

call the MEDICAL SUPPLY MAN!"

You're right doctor. Why be bothered with Fibber McGee closets and hidden dangers when our inventory control system saves you space and releases your working capital too! Buy any of more than 15,000 items at bulk prices but have them delivered and billed as you need them.

Don't fuss and fume over wasted time searching or waiting for supplies! Call the Medical Supply Man! He will be there with what you need almost as soon as you hang up the receiver.

AND there's no need to moan over broken-down equipment either! Our repair specialists are always ready to repair any stubborn bit of equipment on a moment's notice.

Put an end to bothersome details! Let us solve your supply and equipment problems for you. Obey that impulse — *call the MEDICAL SUPPLY MAN TODAY!*

HOSPITAL, PHYSICIANS and LABORATORY SUPPLIES & EQUIPMENT

MEDICAL SUPPLY COMPANY

Essentials For Scientific Progress

MIAMI • of JACKSONVILLE • ORLANDO

230 N. E. THIRD ST.
MIAMI 32, FLA.

420 WEST MONROE ST.
JACKSONVILLE 2, FLA.

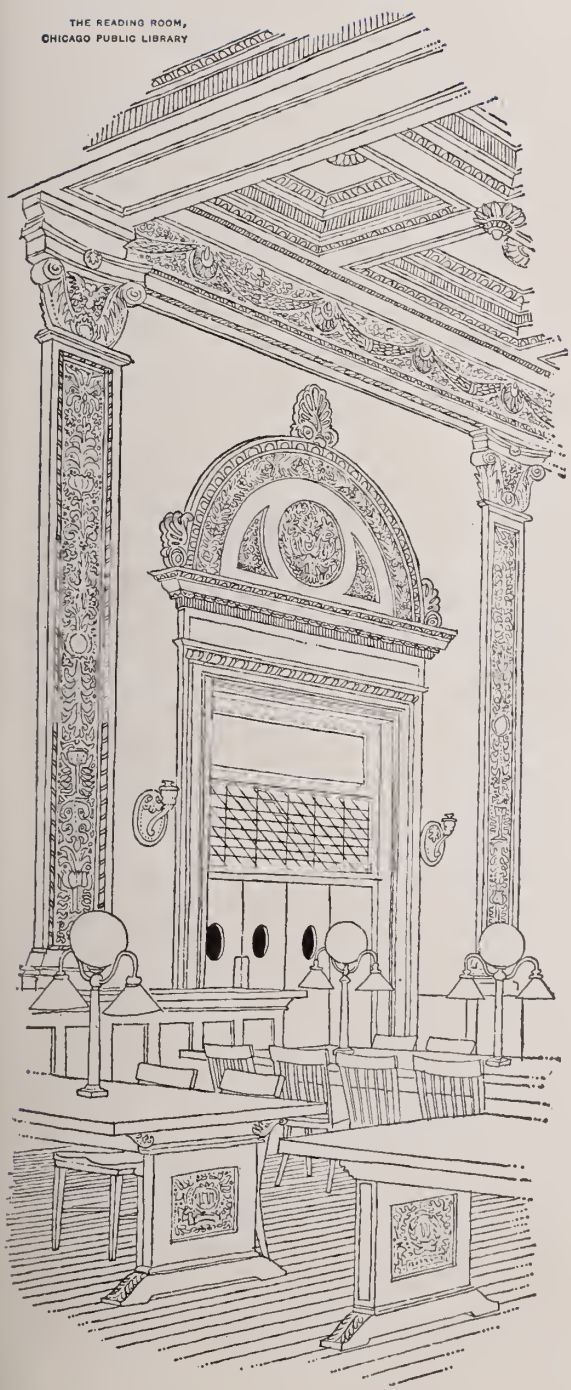
329 N. ORANGE AVE.
ORLANDO, FLA.

New aureomycin minimal dosage for adults—four 250 mg. capsules daily, with milk.

From among all antibiotics, Ophthalmologists often choose

AUREOMYCIN

Hydrochloride Crystalline



because

Aureomycin penetrates the ocular tissues and fluids, after passing the blood-aqueous barrier.

Aureomycin in 0.5% solution is well tolerated by the conjunctiva.

Aureomycin may be used locally in appropriate solution; or by mouth; or, in emergency, intravenously; or by a combined approach, depending upon the seriousness of the infection.

Aureomycin has proved of value in a number of ocular infections in which other remedies have failed.

Aureomycin has been reported to be effective against susceptible organisms in the following conditions commonly seen by ophthalmologists:

Blepharitis
Conjunctivitis
Dendritic Keratitis
Epidemic Keratoconjunctivitis
Episcleritis
Periorbital Infection
Acute Trachoma
Uveitis

Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100.
250 mg.—Bottles of 16 and 100.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
30 Rockefeller Plaza, New York 20, New York

PROVED in three years' clinical use

Cortone®

ACETATE
(CORTISONE ACETATE, MERCK)

Typical experience:

Administration of CORTONE,
systemically, reduced rheumatoid arthritis symptoms
in *all* of 100 patients treated.
Daily maintenance doses of 50 mg. or less, orally,
were adequate in 53 per cent of cases.

Ward, E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.,
Proc. Staff Meet. Mayo Clin. **26**: *361, Sept. 26, 1951.*

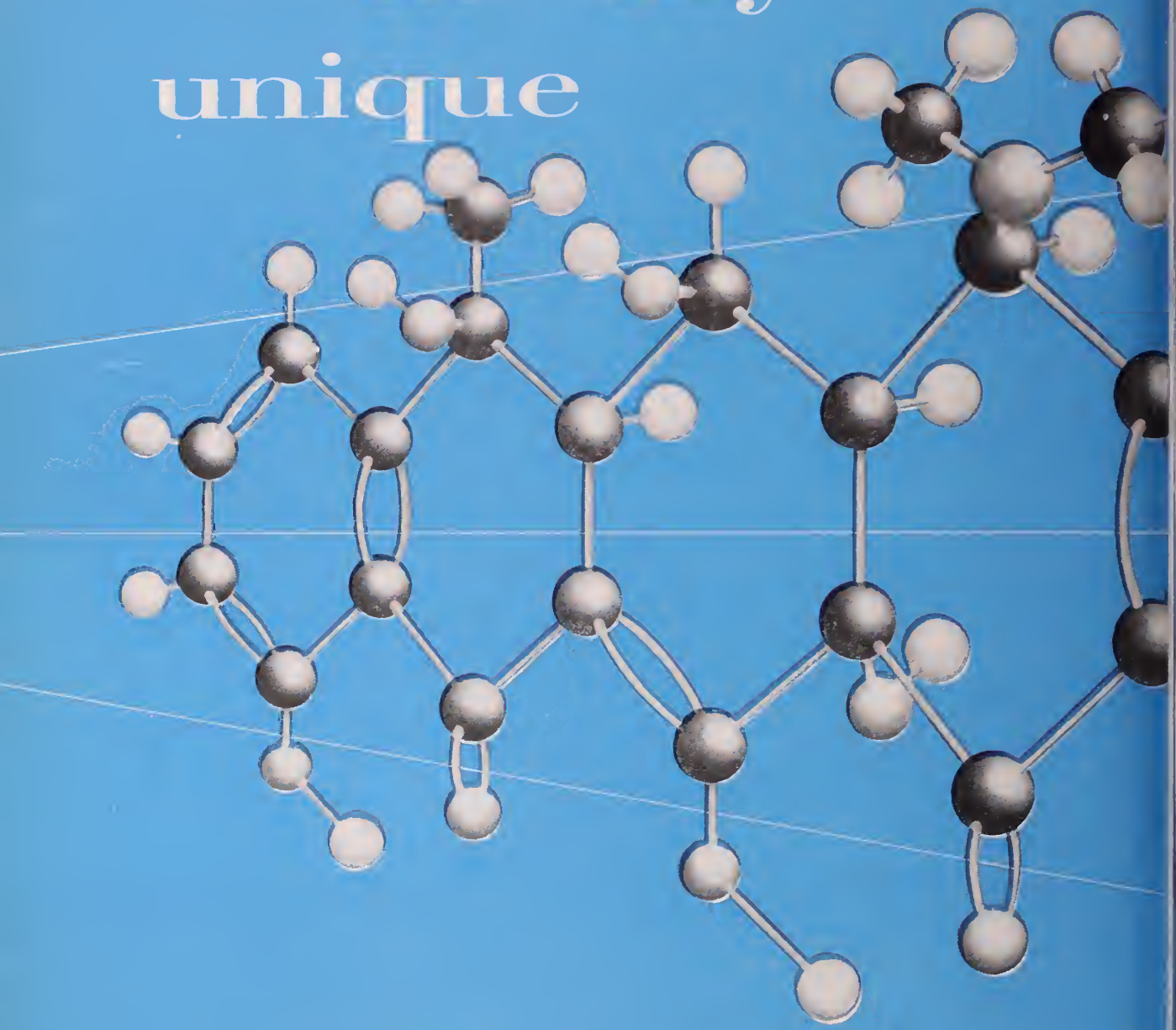
CORTONE is the registered
trade-mark of Merck & Co., Inc.
for its brand of cortisone.

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY
In Canada: MERCK & CO. Limited—Montreal

© Merck & Co., Inc.

there's a
difference...

chemically unique



...as shown by the recent discovery of its molecular structure

Pfiz

clinically unexcelled

Terramycin

for TOLERATION

EFFECTIVENESS

PURITY

POTENCY

ANTIBIOTIC DIVISION, CHAS. PFIZER & CO., INC., BROOKLYN 6, N. Y.

's largest producer of antibiotics

DON'T MISS

APPEARING REGULARLY IN THE J. A. M. A.

Salient facts on the new antituberculous drug...

NYDRAZID

Squibb Isoniazid

	what is known	*what is not known*
Antituberculous effect	Nydrazid has greater potency against the tubercle bacillus than any other known compound, both in vitro and in experimental animals. Clinical results are encouraging. The effect on fever and general status is often dramatic. Roentgenographic improvement occurs often, but is generally slower than in patients treated with streptomycin.	It is too early to predict what the long-term effect of Nydrazid will be. Presumably chronic lesions will not respond better than they do to streptomycin, except insofar as Nydrazid penetrates better. Nydrazid and streptomycin appear to have additive effect in vitro, but it is not known how effective such a combination will be in clinical practice.
Bacterial resistance	Tubercle bacilli with increased resistance to Nydrazid have been isolated from patients. Resistant organisms can also be cultured in vitro, but this phenomenon is virtually eliminated when cultures are exposed to streptomycin and Nydrazid simultaneously.	The clinical implications of bacterial resistance are not completely known. Patients harboring resistant organisms may continue to improve under treatment. The question of delaying the emergence of resistant bacilli by combined therapy must await further study.
Toxicity	Toxic reactions to Nydrazid are chiefly due to stimulation of the central nervous system. They are negligible in the therapeutic dose range, except in patients with convulsive tendencies.	It appears probable that central nervous reactions to Nydrazid can be controlled by barbiturates. But with continued use of the drug, it is not known what sensitivity reactions may occur.

Nydrazid is supplied in 50 and 100 mg. scored tablets, bottles of 100 and 1000.

For further information on Nydrazid send for the Nydrazid Abstract Folder.

SQUIBB

"NYDRAZID" IS A TRADEMARK OF E. R. SQUIBB & SONS

E. R. SQUIBB & SONS
745 Fifth Avenue
New York 22, N. Y.

Please send me a copy of the Nydrazid Abstract Folder.

NAME_____

ADDRESS_____

CITY_____ STATE_____

Dept. B

action substantially without reaction

For those patients in whom penicillin G causes sensitivity reaction, Cer-O-Cillin provides the same antibiotic action but is substantially free from side effects in most cases.

Upjohn researchers developed Cer-O-Cillin (penicillin O) by replacing the benzyl group of penicillin G with an allylmercaptomethyl group, thus making penicillin therapy available to nearly *all* patients.

For action substantially without reaction . . .

Cer-O-Cillin*

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

POTASSIUM

POTASSIUM PENICILLIN O (ALLYLMERCAPTOMETHYL PENICILLIN)

*Trademark

a product of **Upjohn Research**

for medicine . . . produced with care . . . designed for health

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

RELAXED . . . *but awake*

In the many cases which require sedation without excessive hypnosis, Mebaral is of outstanding merit.

With its relatively wide margin between sedative and hypnotic dosage, Mebaral may be employed in those conditions in which relief from anxiety, depression or agitation is desired during the waking hours.

INDICATIONS:

Mebaral affords alleviation of tension in the hyperthyroid or hypertensive patient, relaxation in neuroses and mild psychoses, a calming influence in the high-strung menopausal patient. It is also a reliable anticonvulsant in epilepsy.

Mebaral®

TASTELESS TABLETS

Tablets of 32 mg. (½ grain), 0.1 Gm. (1½ grains) and 0.2 Gm. (3 grains)

WINTHROP-STEARNS INC., New York 18, N.Y., Windsor, Ont.

Mebaral, trademark reg. U. S. & Canada, brand of mephobarbital

Doctor Harris builds a new house

You may be certain that he will insist on a good solid foundation for his new house, consistent with his having built a successful medical practice on sound principles of integrity and dependability. These are the qualities he looks for in others. He has found them to be characteristic of those whose products he chooses to prescribe. Just such a company is now making . . .

Lilly

. . . the hematinic which comes from antibiotic production

Since the antianemia effect of liver was discovered twenty-six years ago, true pernicious anemia has ceased to be a necessarily fatal disease; pharmaceutical refinements have made liver therapy increasingly acceptable; knowledge of the constituents of liver and the nature of anemias has increased. These developments have been helped substantially by teamwork between the Lilly Laboratories and other investigators.

It is now known that several chemically dissimilar substances in liver are effective in macrocytic anemias. For example, vitamin B_{12}, which is also derived as a by-product of Lilly streptomycin production, is usually effective in pernicious anemia. It is ineffective, however, in certain other macrocytic anemias in which folic acid, another natural constituent of liver, is indicated. From investigations such as are continuing in the Lilly Laboratories, it now appears that there are still other unisolated substances in liver which are potent agents capable of producing blood regeneration. Until all of these are identified and their relationships more clearly defined, the use of liver extract in macrocytic anemias will continue as sound therapy.

Lilly ELI LILLY AND COMPANY · INDIANAPOLIS 6, INDIANA, U. S. A.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXIX | Jacksonville, Florida, October, 1952 | No. 4

The Dermatologic Dangers of Sunlight

Morris Waisman, M.D.
TAMPA

The sun is the source of all life on the earth. Its pleasurable warmth and brightness are sought yearly by millions of people who come to Florida from many parts of the world. Throughout the year, by design or by the demands of occupation, tourists and resident Floridians bask in the solar radiance. Taken in moderation, sunshine offers many benefits which are too well known to enumerate. In excess, however, sunshine becomes a potent and dangerous agent, injurious to skin, eyes and internal structures. The range of safe dosage varies widely and is dependent on factors intrinsic in the skin and constitution of the person exposed as well as on the actual amount of actinic energy involved. It is the purpose of this paper to discuss some of the detrimental effects of sunlight both on the normal skin and the skin in pathologic states, as well as to point out means of attaining protection from biologically dangerous radiation.

A brief review of the position of the solar spectrum with reference to the electromagnetic system of radiant energy is pertinent (fig. 1). The effective range of radiation from the sun stretches from the ultraviolet to the infrared, from 2,900Å (angstrom units) to 30,000Å. The shorter wave lengths of sunlight are absorbed by the atmosphere, so that for practical purposes rays shorter than 2,900Å are not encountered on exposure. The region between 2,800Å and 3,100Å is characterized by intense biologic effects, antirachitic, antibacterial, and carcinogenic. Between 2,900Å and 3,100Å the erythemic action or burning effect upon the exposed skin asserts itself. From 3,000Å to 4,200Å, pigmentation is induced in the normal skin. Ordinary glass cuts out wave lengths less than 3,200Å, but transmits the longer wave lengths.

Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 28, 1952.

Among normal skins some are inherently able to tolerate only small amounts of exposure to sun without manifesting erythema and other evidence of injury. The red-headed complexion is most vulnerable, as is widely recognized, followed closely by the blond. The protection offered by the pigment of the brunet skin is exemplified in highest degree by the dark-skinned races. Not only do the lighter colored skins react to ultraviolet radiation more violently with acute burning, but also they show a greater proclivity to chronic damage and resulting aftermaths of serious importance. Nevertheless, the brunet skin is not immune to damage, acute or chronic, if the exposure is sufficiently potent, repeated and prolonged. Nor does pigmentation protect from injury in cases of pathologic hypersensitivity of the skin to the sun's rays.

Sunburn

The teenager dedicated to acquiring the swarthy melanosis which current vogue decrees to be beautiful, or the health faddist baking out his ills and hopefully intent upon absorbing quanta of dynamic energy from the sun, or the ordinary citizen serenely bared, toasting himself for sheer enjoyment of the warmth and indolence — all, in the blissful security of the conviction that "it's good for you," are often heedless of the warning that sunshine might be less than an unalloyed blessing. Often also, until the catastrophe of acute sunburn has been experienced, the burning capacity of sunlight is underestimated by persons exposed.

Because of the added absorption of rays reflected from sand and water, sunburn at a beach will be more severe than after the same length of exposure inland. Loosely woven clothing does not necessarily protect, as those who have been sunburned through a shirt will sadly testify. White fabrics protect less satisfactorily than brown,

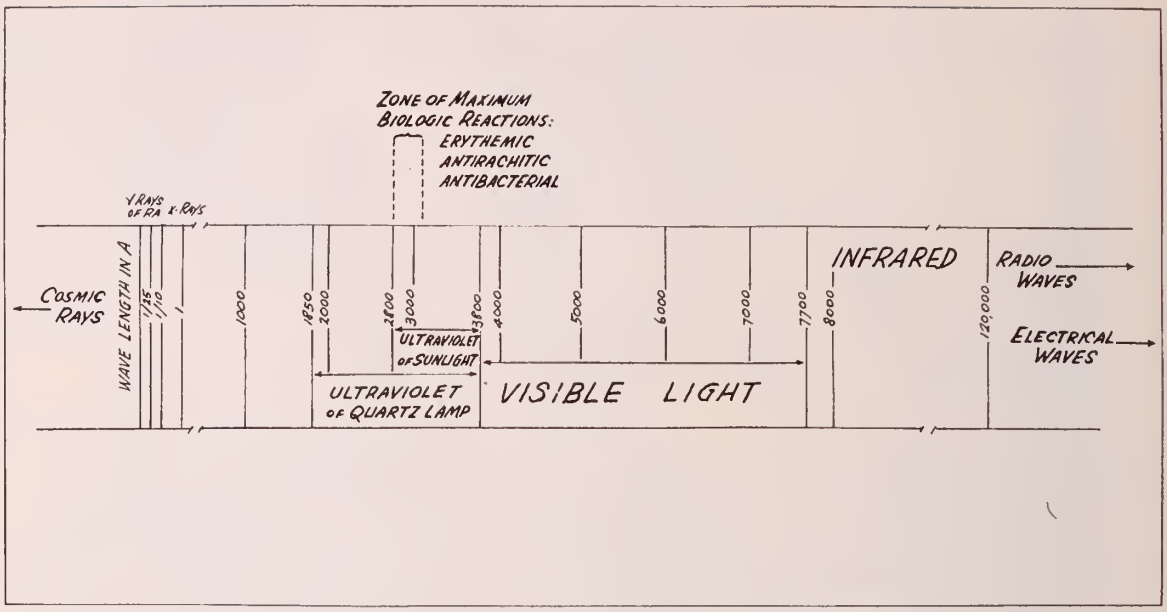


Fig. 1. — Schematic representation of the electromagnetic spectrum.

orange or red, and all fabrics protect less when wet.[1] Smoke absorbs the short wave lengths of sunlight and thus effectively screens, accounting for the paucity of ultraviolet light in industrial centers even in summer. Water vapor, however, allows these rays to pass, so that it is often possible to be badly sunburned on a cloudy day.[2] In Florida during a large part of the year, exposure to sunlight may be particularly hazardous between 11 a.m. and 3 p.m., when the solar rays fall almost perpendicularly. Small children tolerate only about half the adult erythema dose of ultraviolet.

The winter visitor to Florida who spends a few weeks or even a few months out-of-doors is in no great danger as a rule, because the total dose of radiation which he receives in a year is at most probably moderate in amount. This observation is particularly true if he takes pains to graduate his exposure to the sun so that optimal tolerance is achieved by his skin. The year-round resident, however, exposed daily to the maximum intensity of the sun, may suffer a considerable degree of cutaneous damage. Especially important is this possibility in the case of elderly people, whose skins are already vulnerable by virtue of senile changes present.

The natural protection of the skin against sunburn consists of a dual mechanism manifested by (1) thickening of the horny layer of the epidermis as a result of exposure to sunlight, and (2) melanin pigment developing in the epidermis.[2] The stratum corneum may thicken as much as sixfold in response to exposure to ultraviolet radiation, forming a mantle relatively opaque to the rays that cause sunburn. This is the principal method of achieving protection of the skin of white peoples, as distinguished from the melanin pigmentation which serves more importantly in the dark-skinned races. The sunburn spectrum (2,900Å to 3,100A) results in formation of new pigment in the skin; but another source of pigmentation lies in the spectrum of longer wave lengths (3,000Å to 4,200Å), which results in the darkening of pigment already present in a "bleached" or colorless form. From these data it is evident that tanning can be induced without preliminary burning. The gonadal steroid hormones (estrogens and androgens) play a physiologic role in influencing pigmentation.[3]

The manifestations of acute sunburn need not be described. All are familiar with the fiery pain, the wretchedness, the toxicity of the person who because of accident or ignorance or wilfulness has suffered an incandescent sunburn. Less familiar is the development of certain complications or sequelae of acute sunburn, which are enumerated: (1) Herpes simplex may appear, usually circumoral, representing the activation of dormant virus resident in the cells of the epidermis. (2) Folliculitis, occurring extensively over the sunburned parts, may develop as a result of hyper-

keratotic blocking of the sebaceous and sweat ducts. These structures are then predisposed to secondary infection because of the interference with free drainage of secretion from the ducts to the surface of the skin. (3) Vitiligo, the complete disappearance of pigment in areas of the skin, may be due to actinic destruction of the enzyme systems which regulate formation of melanin. (4) Chloasma, blotches of increased pigmentation, may first evolve after a sunburn and persist indefinitely, fading somewhat in the winter season but not disappearing completely. (5) "Showers" of pigmented nevi occasionally follow acute sunburn or accompany the subsequent tanning, particularly in children. (6) Persistent increased susceptibility to sunlight may result, representing a lowering of the erythema threshold, so that abnormally severe burning ensues upon re-exposure to relatively small doses of ultraviolet.

Prevention of Sunburn. Sunburn is easily preventable, and prevention may be attained by natural means or by the use of chemical and physical screens. The first exposure of the unadapted and unprotected skin must be short, and the time of exposure must be increased gradually as tanning and thickening of the epidermis proceed. In this way increasing tolerance can be safely developed.

By the judicious application of chemicals which absorb ultraviolet rays, sunburn can be prevented or minimized almost without regard to complexion or length of exposure. Chemical filters, effective in varying degrees, are: para-aminobenzoic acid and esters, phenyl salicylate, benzyl salicylate, menthyl salicylate, naphthol sulfonates, quinine and derivatives, esters of methoxy-coumaric acid, esters of anthranilic (ortho-aminobenzoic) acid, tannic acid and pyribenzamine. It is necessary to warn that any of these may be a cutaneous sensitizer, and para-aminobenzoic acid has even been detected in the anomalous role of a photosensitizer.[4]

Physical screens obviously bar the transmission of the sun's rays, and of these the wearing of adequate clothing is the most successful measure. Hats, gloves and umbrellas are of distinct help. Tying a handkerchief across the lower half of the face when in the sun, or sticking a slip of tissue paper across the lower lip, may avert serious solar injury to the lip. Effective also are face powders (titanium dioxide), zinc oxide, zinc stearate, bismuth subcarbonate, yellow petrolatum and red veterinary petrolatum. Proprietary baby oils which are commonly employed as suntan lotions have little if any antiburn value; and the practice of introducing iodine adds nothing to the sun-screening capacity of the oil.

A great number of sunburn preventives are marketed commercially. Some are most effective; many are inadequate; and a few of them indeed give no protection whatever.[5] To maintain effective shielding against sunburn, the preparation must be reapplied after an hour or two of exposure and after each swim. In hot weather, when perspiration dilutes and disperses the suntan agent, more frequent applications are of course necessary.

Satisfactory sunburn preventives may be prepared as follows:

Cream

Para-aminobenzoic acid 15 per cent in Ruggles' vanishing cream or other greaseless base. (Formula of Rothman and Henningsen.[6])

Lotion

Isobutyl-para-aminobenzoate	5 per cent
Alcohol	60 per cent
Glycerin	10 per cent
Water	25 per cent

The addition of 2 per cent tanic acid will help to simulate suntan and increase the sunburn-preventive action. (Formula of Schwartz and Peck.[7])

Farmer's Skin (Chronic Solar Dermatitis) and Skin Cancer

In persons exposed to sunlight over long periods of time — farmers, fishermen, cattlemen, building tradesmen, and devotees of outdoor sports and avocations — there develop prematurely senile changes of the skin (chataigne, or weatherbeaten, or farmer's or sailor's skin). The sandy or ruddy complexion which freckles readily is most predisposed to this change. The exposed parts become leathery, wrinkled, inelastic, freckled, telangiectatic, and spotted with precancerous keratoses (fig. 2a). The vermilion border of the lower lip becomes dry, fissured, pale and atrophic (solar cheilitis), and keratoses are likely to appear on its surface (fig. 2b). Degenerative changes of the connective tissue of the exposed skin lead to yellow discoloration, pebbling and deep wrinkling of the face and to the well-known rhomboidal furrows (cutis rhomboidalis nuchae) which cross-hatch the nape of the neck (fig. 2c). When chronic solar injury affects the backs of the

hands, multiple transient, small, irregular, purplish red petechiae may appear from time to time. Known as purpura solaris, the disease is probably caused by degeneration of the connective tissue and capillaries of the cutis.[8] So-called colloid degeneration of the skin is yet another, and rare, dermatosis in which solar injury of the connective tissue produces multiple yellowish translucent papules on the face and hands.

Fig. 2.—Chronic solar injury of the skin. (a) Chronic solar dermatitis (farmer's skin) showing multiple freckles and senile keratoses. Cancerous changes are already present in the crusted lesions. (b) Areas of pallor, keratosis and crusting in chronic solar cheilitis. (c) Cutis rhomboidalis nuchae: the typical quadrangular pattern of the sulci.

Cancers of the skin, the commonest of all malignant growths, predominate among outdoor workers of the white race, being practically absent in Negroes and Indians. Cancers of the skin, including the lip, occur much more commonly in the Southern part of the United States than in the Northern part.[9] It is safe to say that the incidence in Florida is at least five times that in Northern states. Moreover, the development of cancer of the skin among young adults (second, third, and fourth decades) in the South far exceeds the frequency of these neoplasms in the same age groups in the North.

Lesions appear chiefly on the exposed portions of the skin, the face, neck, and hands. Blonds are subject to skin cancer more than brunets, and redheads have the greatest susceptibility of all. The majority of patients with cancer of exposed surfaces of the skin have eyes of light color, that is, other than brown. Hall[10] has shown that the more brown-eyed inheritance a person possesses, the better protected he is from the carcinogenic rays of the sun. Blue-eyed descendants of blue-eyed parents are most susceptible as a group. Undoubtedly the brown-eyed skin averages a thicker stratum corneum, which accounts in large measure for its resistance to carcinoma. The wave lengths responsible for the formation of cancer are of the same spectral range as those of sunburn. Experimentally, it is possible to produce malignant tumors in the skin of white mice and rats by exposing them to sunlight or to radiation from a mercury arc lamp.

Carcinomas of the skin, both basal cell and squamous cell, develop upon chronically sunburned skin. It has been shown that 20 per cent to 25 per cent of senile keratoses in time eventuate in epitheliomas of the squamous cell type.[11] When it is considered that annually in the United States some 3,000 persons die of cutaneous malignant disease, the seriousness of the problem becomes apparent. If greater effort were made toward education of the public regarding the influences which lead to precancerous and cancerous changes in the skin, much might be achieved toward reducing the incidence of the commonest form of cancer.

Another common lesion of the skin related to the effect of sunlight is the "senile freckle" or lentigo (fig. 3a). This superficial, pigmented macule appears usually on the face and backs of the hands and forearms and tends slowly to increase in size. It is generally harmless. Occasionally a malignant transformation occurs which results in the lesion known as lentigo maligna. Lentigo maligna is a melanoma, circumscribed in situ for a time, but with the distinct capability for growth and widespread metastasis characteristic of all melanomas.

Somewhere in this area of classification of pigmentary lesions associated with chronic solar exposure must be listed parenthetically the persistent punctate, pigmented, and telangiectatic patches on the sides of the neck and the "V" of the chest designated *dermatose du triangle sternoclaviculare* by Brocq[12] in 1916 (fig. 3b). This abnormality is observed predominantly in women. It is benign and of cosmetic importance only.

An aspect of the subject of carcinogenic effects of solar radiation which is usually side-stepped concerns the relationship of outdoor occupation and the development of cutaneous malignant disease. There is no doubt that in many instances the causal relationship of job to cancer is clear. In other cases the connection is equivocal, obscure,

or complicated by such factors as the workman's outdoor avocations and solar damage to the skin from nonoccupational exposure in earlier life. Preemployment examinations, for screening out persons with skins unsuitable for outdoor work, will probably in time become essential. To establish pertinent principles of guidance for the physician and the insurer is a project which awaits thoroughgoing study. Sooner or later this issue must be faced realistically by industrial commissions and an equitable solution worked out; and almost certainly the same problem will have to be acted upon also by the military services and the Veterans Administration.

Fig. 3.—Pigmented lesions attributable to the effects of sunlight. (a) Lentigines of the hands and forearms. (b) Punctate pigmentation and telangiectasis of the neck.

Xeroderma Pigmentosum

A rare familial disease, xeroderma pigmentosum (fig. 4) begins early in childhood when the skin of the exposed parts, because of hypersensitivity to sunlight, becomes thickened and develops freckles, keratoses, telangiectases, angiomas, and white atrophic spots. Photophobia and ectropion of the lower eyelids appear as the disease progresses. Later, atrophic and degenerative changes take place, leading to features of far advanced senile skin, actually a severely exaggerated farmer's skin. Neoplastic changes follow, with the formation of multiple carcinomas, basal or squamous celled, sarcomas, melanomas and other growths, benign or malignant. The child ultimately succumbs to a metastatic carcinoma.

Fig. 4.—Xeroderma pigmentosum. Freckles and keratoses are widespread. Compare with figure 2a.

Xeroderma pigmentosum is a mendelian recessive characteristic, and the parents are often consanguineous. Patients are sensitive to ultraviolet rays especially in the sunburn range. Sunburn radiation, however, only precipitates or accelerates the lesions of xeroderma pigmentosum, for apparently the condition may develop even in the absence of such radiation. Nevertheless, much can be accomplished in retarding the onset and rate of malignant degeneration if the child is completely shielded against exposure to the sun.

Solar Urticaria

Solar urticaria is a manifestation of photosensitivity in which brief exposure to sunshine produces a wheal within a few minutes, followed by an irregular flare spreading outward to the unexposed skin. The reaction, accompanied by intense itching, recedes or disappears within a few hours. Two types of urticarial light hypersensitivity are recognized: (1) that due to wave lengths below 3,700Å, a rare form, in which passive transfer of the sensitivity is demonstrable, indicating the presence of a circulating antibody;[13] and (2) that due to wave lengths above 3,700Å (visible light), in which passive transfer cannot as a rule be achieved.[11] Two different mechanisms are therefore probably involved. The action spectrum for the second group usually lies in the violet-blue portion of visible light (4,000Å to 5,000Å); hence wheals will develop even after exposure to sunlight through window glass, and

fluorescent lamps may elicit lesions whereas tungsten filament lamps will not. Because chemical filters are ineffective, recourse must be had to physical screens for protection. In the treatment of solar urticaria, antihistamine drugs are occasionally of benefit.

Solar Eczema (Polymorphic Light-Sensitive Eruption)

In solar eczema, pale itching papules or nodules appear on exposed areas, especially the backs of the hands, the face and the neck (fig. 5a), or an eczematous eruption develops. At times pinkish, thickened, unpigmented plaques occur on the cheeks and the neck. The condition predominates in females. Usually the eruption presents itself during the early spring, but sometimes there is no seasonal remission of the lesions in Florida, as contrasted with parts of the country where winters are long. By summer solar eczema may heal entirely even though exposure to sunlight continues, only to reappear the following spring. Most cases are evoked by abnormal sensitivity to rays of the sunburn spectrum. A few cases, however, respond to longer wave lengths as shown by the formation of lesions when sunlight is passed through window glass and by the failure of chemical filters such as para-aminobenzoic acid to protect. Lamb and his associates[15] stated that fluorescent lights might provoke and prolong a light-sensitive eruption.

Hydroa Aestivale

Hydroa aestivale is manifested by bullae of various sizes containing clear or discolored fluid, confined to the exposed parts and sometimes accompanied by edema (fig. 5b). When familial, hydroa appears in boys during early childhood, usually in spring or summer. In nonfamilial cases girls predominate 2 to 1.[16] The active wave length seems to be about 5,000Å, within the visible spectrum.

Two types are recognized: (1) hydroa with porphyria, in which blisters are large, not umbilicated, and attacks recur throughout life, associated with necrosis of skin and scarring, and even destruction of parts such as the nose, ears, and fingers; (2) hydroa without porphyria, which presents fewer but umbilicated lesions, less scarring or none at all, and spontaneous halting of the disease after puberty. Successful treatment of hydroa with steroid and gonadotropic hormones has been reported.[17]

Porphyria

Porphyrins constitute an integral part of the molecule of certain respiratory pigments, notably hemoglobin, myoglobin and cytochrome. Porphyrins originate in the body during the process of hemopoiesis, and not from the destruction of hemoglobin. The familial metabolic error which results in abnormal kinds and amounts of porphyrins excreted in urine and feces is known as porphyria. It perhaps represents a persistence of fetal porphyrin metabolism. Three clinical groups are recognized, congenital, acute, and chronic porphyria.

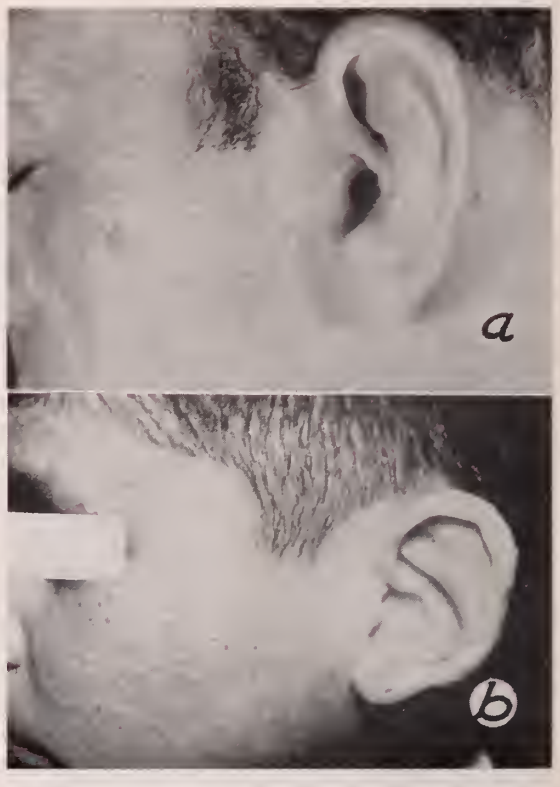


Fig. 5.— (a) Polymorphic light-sensitive eruption consisting of pale papules and discoid nodules. (b) Vesicles and crusts over face and ears of a boy with hydroa aestivale. (Photograph courtesy of Dr. Paul Fasal.)

Congenital porphyria is a chronic disease characterized by photosensitivity, with blistering and scarring of exposed parts. It appears at birth or early in life, predominantly in males, inherited as a mendelian recessive trait. Large quantities of porphyrin are excreted in the urine, to which may be imparted a dark red color. The teeth and bones may be discolored red by impregnated uroporphyrin.

Acute porphyria[18] is manifested by recurrent and alarming symptoms referable to the abdomen (nausea, vomiting, colic) or central nervous system (sensory disturbances, paralyses, convulsions, coma, psychotic behavior). The disease does not usually appear until the third or fourth decade of life. Occurring three times as frequently in females as in males, acute porphyria is transmitted as a mendelian dominant. Photosensitivity is rare.

Chronic porphyria presents increased porphyrin excretion, mild photosensitivity with a tendency to bullous lesions, and episodes of abdominal colic. Abnormal blistering after mechanical trauma may also occur. Sometimes pigmentation and hypertrichosis are evident. These cases possibly represent either congenital or acute porphyria in a mild form. Chronic porphyria may be present in a latent state, from which it can be stimulated to activity, usually in adult life, by damage to the liver from disease, alcohol, drugs, or other toxic influences.[19] In most cases the cause is indeterminate.

It will be readily appreciated from the foregoing that the relationship of porphyria to photosensitivity is far from constant. In fact, most patients with photodermatoses excrete normal amounts of urinary porphyrin. But more patients with photodermatoses have increased urinary porphyrin levels than those with other dermatoses. Porphyrins may ultimately be shown to be inactive associates or products of photosensitization reactions rather than their cause.[20]

Photosensitization by External Contacts and by Internal Drugs

A few chemicals have the ability to produce a dermatitis if their contact with the skin is followed by exposure to sunlight. The wave lengths which produce photosensitizing effects are those absorbed by the particular photosensitizer (Grotthus-Draper law). Photosensitization of this type is achieved by certain plant products and derivatives of coal tar and is characterized by the appearance of dermatitis with pigmentation.

In meadow grass dermatitis (originally described by Oppenheim in 1926) itching blisters in an irregular, streaked and criss-crossed pattern appear within 24 hours after a sun bath on a grassy field or after walking bare-legged in weeds (fig. 6a). They heal with pigmentation, which may persist for months (fig. 6b). Meadow grass dermatitis is probably not uncommon in the United States, and Oppenheim[21] suggested that some cases are mistakenly diagnosed dermatitis venenata due to poison ivy or other external irritant. Undoubtedly the precaution of sun-bathing on towels or blankets reduces the incidence of this eruption.

At least fourteen plants have been identified which are capable of producing photodermatitis of this kind, the majority of them belonging to the families Umbelliferae (parsnip, yarrow, angelica) and Rutaceae (common rue, gas plant, lime).[22] The photosensitizing chemicals responsible for the reaction are believed to belong to the group of furocumarins. These sensitize the skin for long ultraviolet waves, especially around 3,340Å to 3,660Å.

Berlock dermatitis, the most frequent form of photodermatitis, is caused by oil of bergamot present in cologne and perfume. Pigmented areas appear corresponding to the site of application of the liquid (fig. 6c). These lesions at times assume the configuration of a drop, due to running of the liquid after its application (hence the name berlock, or breloque, signifying a locket or ornament suspended on a chain, which is suggested by the characteristic linear appearance).

To Dr. Wiley Sams[23] of Miami belongs the distinction of recognizing, investigating and describing the commonest photodermatitis of Florida, which he showed was due to the oily fraction of the peel of the Persian lime (Citrus aurantifolia, var. Swingle). Contact with the peel, as in preparing limeade, followed by exposure to the sun, causes within 24 hours the appearance of erythema, often to the extent of severe sunburn with blisters, but associated with minimal discomfort or pruritus. A brownish discoloration, usually on the hands and forearms and occasionally on the face, gradually replaces the erythema (fig. 6d). Pigmentation may persist for as long as six months. Sams proved that the longer wave lengths of ultraviolet rays are involved, just below the zone of visible light (3,100Å to 3,700Å).

A similar photodermatitis has been reported among persons handling figs or coming in contact with the fig tree.

Coal tar pitch, heavy coal tar distillates, petroleum products and asphalt are photosensitizers, causing an erythematous dermatitis followed by pigmentation among men working with them out-of-doors.[24] Rays with longer wave lengths, rather

than those of the sunburn spectrum, are responsible. Nonpigmenting photodermatitis of the lips may be produced by fluorescent coal tar dyes in lipsticks.

Fig. 6.—Photosensitization by external contacts. (a) Linear and criss-crossed bullae, and (b) striate pigmentation characteristic of meadow grass dermatitis. Observe the complete freedom of the area of the skin covered by bathing trunks. (Photographs courtesy of the late Dr. Maurice Oppenheim.) (c) Pigmented streaks on neck caused by application of cologne. The classical berlock or "running drop" effect is not present in this case. (d) Photodermatitis of fingers and hand from contact with oil of Persian lime.

Some fluorescent dyes (eosin, erythrosin, rose bengal, acridine dyes, hematoporphyrin) when injected into animals elicit, on exposure to sunlight, pruritus and edematous swelling of the face and ears, followed by necrosis of the skin in these areas. Occasionally barbiturates produce photoallergic effects. Sulfonamides are a relatively frequent cause of photosensitization, provoking an eruption which is usually morbilliform, becoming confluent and often associated with itching, fever and malaise. Less commonly present are edema, urticaria and vesiculation. Photodynamic contact dermatitis has been reported from the use of sulfanilamide ointment.

Photodynamic diseases occur in cattle, horses, sheep, goats and swine which have fed on certain plants before exposure to direct sunlight.[25] Similar photosensitization by foods has not been proved in man.

Diseases Associated with Sensitivity to Sunlight

Among certain diseases photosensitivity is presumed to be an inherent part of the morbid process. The relationship of the cutaneous lesions of pellagra to sunlight has long been recognized. In some cases, however, the distribution of the eruption is not in areas exposed to light; for example, the inguinal region may be affected. Apparently sunlight itself does not play the important role in pellagra that has been traditionally emphasized, and in many cases there is no unusual susceptibility to light.[2]

All types of lupus erythematosus often, but not always, become exacerbated on exposure to sunlight, and this exacerbation is particularly true of the acute and subacute disseminate types. The chronic discoid type, which is not associated with systemic manifestations or evidence of visceral disease, may or may not be aggravated by sunlight. Possibly the etiologic role of sunlight in lupus erythematosus has been excessively stressed. Many patients with chronic discoid lupus erythematosus suffer no evident harm from working in the sun, and they exhibit no improvement after exposure to the sun is eliminated. When exacerbation occurs in lupus erythematosus, the effective spectrum is probably in the sunburn band.

Acne vulgaris, acne rosacea and seborrheic dermatitis are occasionally made worse by exposure to sunlight (the adverse effect of concomitant summer heat is almost inseparably associated). So also are some cases of eczematoid eruptions (contact dermatitis, neurodermatitis, exfoliative dermatitis), "toxic" erythemas and erythema multiforme. Although not constant or predictable, the deleterious influence of sunlight is manifested sufficiently often to multiply the problems of dermatologic management of these diseases in tropical and subtropical climates. The effect of sunlight on the exanthem of smallpox is reputed

to be unfavorable. A papular photosensitivity eruption may accompany lymphogranuloma venereum. And finally, some cases of hyperthyroidism and pulmonary tuberculosis exhibit abnormal sensitivity to the sun, so that the patients may suffer considerable systemic reaction even with minimal burning of the skin.

Summary

This paper concerns itself with the detrimental effects of excessive sunlight on normal and pathologic skin. Variable degrees of susceptibility to ultraviolet radiation are exhibited normally, depending upon the complexion as well as upon the intensity and duration of exposure. Complications and sequelae of acute sunburn include herpes simplex, folliculitis, vitiligo, chloasma, pigmented nevi and persistent decreased tolerance to ultraviolet rays. Protection from sunburn may be achieved by graduated exposures to the sun, chemical filters and physical screens.

The development of so-called farmer's skin, or chronic solar dermatitis, is the most important effect of damage due to prolonged exposure of the skin to sunlight. Upon skin thereby altered, precancerous and cancerous lesions almost invariably appear. In emphasizing the carcinogenic role of ultraviolet rays, a plea is made for increased effort to disseminate an alarm against the peril of injudicious and indiscriminate exposure to the sun.

Uncommon and rare solar hypersensitivity dermatoses are xeroderma pigmentosum, solar urticaria, solar eczema and hydroa aestivale. These are described, together with some aspects of abnormal porphyrin metabolism. Much commoner are erythematous and pigmentary eruptions caused by plant products and coal tar derivatives if exposure to sunlight follows their contact with the skin. The chief entities in this category are meadow grass dermatitis, berlock dermatitis, lime oil dermatitis, and tar and pitch melanosis. Mention is made of the photosensitizing properties of some drugs, particularly the sulfonamides.

The relationship of photosensitivity to certain systemic diseases, notably pellagra and lupus erythematosus, is reviewed. Also noted is the deleterious effect of sunlight on dermatoses of the acneform, eczematoid and erythematous groups. In these cases the disturbing influence of the sun is inconstant, but it occurs with sufficient frequency to magnify the difficulties of dermatologic treatment in the subtropical climate of Florida.

References

1. Blum, H. F.; Eicher, M., and Terus, W. S.: Evaluation of Protective Measures Against Sunburn, Am. J. Physiol. 146:118-125 (April) 1946.
2. Blum, H. F.: Photodynamic Action and Diseases Caused by Light, American Chemical Society Monograph Series, No. 85, New York, Reinhold Publishing Corp., 1941; Radiation: Photophysiologic and Photopathologic Processes, in Glasser, Otto, editor, Medical Physics, Chicago, Year Book Publishers, 1944, pp. 1145-1157.
3. Hamilton, J. B.: Significance of Sex Hormones in Tanning of Skin of Women, Proc. Soc. Exper. Biol. & Med. 40:502-503 (March) 1939.
4. Satulsky, E. M.: Photosensitization Induced by Monoglycerol Paraaminobenzoate: Case Report, Arch. Dermat. & Syph. 62:711-713 (Nov.) 1950.
5. Sunburn Preventives, Consumer Reports 13:301-303 (July) 1948.
6. Rothman, S., and Henningsen, A. B.: Sunburn-Protecting Effect of Para-Aminobenzoic Acid, J. Invest. Dermat. 9:307-313 (Dec.) 1947.
7. Schwartz, L., and Peck, S. M.: Cosmetics and Dermatitis, New York, Paul B. Hoeber, Inc., 1946, p. 145.
8. Berlin, C.: Purpura Solaris, Acta dermat.-venereol. 20:77-93 (Feb.) 1939.
9. Elliott, J. A., and Welton, D. G.: Epithelioma; Report on 1,742 Treated Patients, Arch. Dermat. & Syph. 53:307-332 (April) 1946.
10. Hall, A. F.: Relationships of Sunlight, Complexion and Heredity to Skin Carcinogenesis, Arch. Dermat. & Syph. 61:589-610 (April) 1950.
11. Montgomery, H.: Precancerous Dermatosis and Epithelioma in Situ, Arch. Dermat. & Syph. 39:387-408 (March) 1939.
12. Brocq, L.: Cited by Blum.[2]
13. Blum, H. F.; Baer, R. L., and Sulzberger, M. B.: Studies in Hypersensitivity to Light; Urticaria Solare, J. Invest. Dermat. 7:99-107 (April) 1946.
14. Blum, H. F.; Barksdale, E. E., and Green, H. G.: Urticaria Solare, J. Invest. Dermat. 7:108-115 (April) 1946.
15. Lamb, J. H., and others: Solar Dermatitis, Arch. Dermat. & Syph. 62:1-27 (July) 1950.
16. Epstein, S.: Studies in Abnormal Human Sensitivity to Light; Prurigo Aestivalis, Eczema Solare and Urticaria Photogenica. Report of 17 Cases and Review of Literature, J. Invest. Dermat. 5:187-196 (Aug.) 1942.
17. Lamb, J. H.; Lain, E. S.; Keaty, C., and Hellbaum, A.: Steroid Hormones: Metabolic Studies in Dermatomyositis, Lupus Erythematosus and Polymorphic Light-sensitive Eruptions, Arch. Dermat. & Syph. 57:785-801 (May) 1948.
18. Nesbitt, S.: Acute Porphyria, J. A. M. A. 124:286-294 (Jan. 29) 1944.
19. Brunsting, L. A., and Mason, H. L.: Porphyria with Cutaneous Manifestations, Arch. Dermat. & Syph. 60:66-81 (July) 1949.
20. Zeligman, I.: Urinary Excretion of Porphyrin in Dermatoses, Arch. Dermat. & Syph. 54:281-291 (Sept.) 1946; Correction 54:772 (Dec.) 1946.
21. Oppenheim, Maurice: Personal communication, March 5, 1949.
22. Bellringer, H. E.: Phyto-Photo-Dermatitis, Brit. M. J. 2:984-986 (June 4) 1949.
23. Sams, W. M.: Photodynamic Action of Lime Oil (Citrus aurantifolia), Arch. Dermat. & Syph. 44:571-587 (Oct.) 1941.
24. Foerster, H. R., and Schwartz, L.: Occupational Melanosis from Pitch, Arch. Dermat. & Syph. 39:955-968 (June) 1939.
25. Mathews, F. P.: Photosensitization and Photodynamic Diseases of Man and Lower Animals, Arch. Path. 23:399-429 (March) 1937.

706 Franklin Street.

Discussion

Dr. Wiley M. Sams, Miami: The problems or disorders of the skin which we see following exposure to sunlight have been of interest to me for a number of years. I am happy, therefore, to have Dr. Waisman give us such an excellent factual account of these disturbances and review some of the more common ones which are rather frequently encountered in Florida, more so in this climate than in most places because of the large number of people who expose themselves to the sun. There is need for constant reappraisal of the dangers which may result from injudicious exposure to the sun because our state largely relies upon its climate and its sun for its attraction to tourists, and some of them incur difficulty during their sojourn, and sometimes they resolve not to return.

The person with a fair florid skin needs to be constant-

ly warned when he first exposes himself to the sun in Florida, and even then he fails to take adequate precautions in a good number of cases and receives a severe sunburn, or it may cause an exacerbation of some already existing dermatitis. We are perhaps less aware of many of the common factors in the ageing process of the skin which are due to repeated exposure and accumulation of injury from light over a period of years. Dr. Waisman has pointed out a number of these. I think the "turkey neck," the reddened neck which we see so frequently in fishermen and farmers, is recognized by all of us. Colloid degeneration of the skin, of which he had an excellent illustration, is not commonly recognized, but perhaps it is not so rare as we might suppose if we will keep on the alert for the changes in the skin that occur usually over the dorsum of the hands and the wrists.

The skin cancer problem in Florida and in the Southwest is more prevalent than in other parts of the country, and it reflects excessive exposure to sun. The general belief among most of our patients and most of our tourists that there is something which they absorb from the sun which rejuvenates them is, I think, the basis for most of the sun worship that we see. Actually, I believe that it is the rest and change of environment that lead to the improvement and not the effects of sun exposure.

DR. LEWIS CAPLAND, Miami Beach: In discussing a presentation, the discusser must find points of disagreement or points for amplification, or present some additions which might be of interest to the audience. I am unable to disagree with or amplify anything Dr. Waisman has said. So I thought I would add a few points which might be of interest to the audience.

The acute effect of sunburn on the peripheral circulation of the lower legs is an effect of immediate concern. By that I mean the consequences of sunburn on the lower legs of the older age group of the sun worshipers secondary to pronounced vascular dilatation. These effects are twofold: one is a dependent edema of considerable degree, and the other is a moderate to decided purpura and ecchymosis. Apparently the acute dilatation of the dermal blood vessels precipitates a latent varicose state which is unable efficiently to take care of the increased circulation. We see many patients with an edema which persists for ten or twelve days after the sunburn who can only be helped by ace bandages and bed rest. The other is the mild to great diapedesis occurring in the old blood vessels which are forced to dilate beyond their capacity; their fragile walls open up and let loose the red blood cells into the skin. The resultant purpura and ecchymosis are most disconcerting unless recognized and the patient reassured.

The next cases of interest are the results of the use of sunburn and suntan lotions, creams and oils. Here we have a group of cases which I have not been able to classify completely in my own mind. I have just pulled 200 records out of my files. I have crudely divided these cases into three groups: the urticarial photosensitivity group, the contact dermatitis group, and the contact type of photosensitization. The urticarial group occurs early after exposure to sun and application of oil. These cases are characterized by pruritus and urticaria. The patients must stay out of the sun, and when clear — and I say advisedly when clear, because a certain number of those in whom this urticarial reaction develops cannot return to sunbathing — may attempt sun exposure. This abnormal eruption may persist from two to six days. A certain number, as I said before, cannot reappear in the sun, and this limitation is most bothersome because we on the beach see people who come down only for two or three weeks at a time. They go immediately out in the sun, this eruption develops, and then their entire vacation is ruined.

The other contact dermatitis group comes from para-aminobenzoic acid, as Dr. Waisman has mentioned, and other materials in the suntan lotions and creams. These cases react and act like ordinary weed contact dermatoses, and of course the condition is the one with which we are all familiar. The third or contact photosensitization group gives the appearance of contact dermatitis, but is not related to a definite epidermal chemical sensitization.

DR. WAISMAN, concluding: I wish to thank the discussers. In closing, I should like to point out that the control of this problem of chronic solar dermatitis is essentially one of prevention, and since we are dealing with a condition which is undoubtedly caused by cumulative damage to the skin, I believe that it is our obligation to start the preventive program at the earliest possible age. In other words, our problem, I think, will be solved by starting the program of protection of the skin in childhood.

MEDICAL DISTRICT MEETINGS

Panama City, Oct. 27, 1952

Fort Pierce, Oct. 30, 1952

St. Petersburg, Oct. 29, 1952

Daytona Beach, Oct. 31, 1952

Exchange Transfusion in Erythroblastosis Fetalis

James J. Griffitts, M.D.
MIAMI

Erythroblastosis fetalis is a disease of infants caused by the specific action of maternal antibody on fetal antigen. The most important single determinant of damage to the infant in utero is the amount of maternal antibody which reacts with the specific antigen present in the infant's red blood cells.

At the Blood Bank of Dade County properly controlled maternal serum-antibody studies have furnished valuable diagnostic and prognostic information to the obstetrician and pediatrician. Data reported herein indicate the reliability of the information obtainable in the laboratory. The often expressed failure of the laboratory to provide prognostic information is due, in our opinion, to inaccurately performed laboratory procedures. There is a strong association between the level of maternal antibody and the degree of damage to the infant, a logical finding in view of the pathogenesis of this disease.

The understanding of the relation of maternal antibody titer to fetal and infant damage allows a rational approach to the management of the infant disease. While the details of the various blood antigens and antibodies are beyond the scope of this report, certain general features of the immunologic aspects of erythroblastosis fetalis will be presented. It must be stressed that the laboratory procedures involved in Rh antibody titrations must be properly controlled at all times in order to derive the valuable information which is available.

Case Data

The studies reported here represent 192 consecutive cases of immunized mothers bearing Rh positive infants. In the majority of cases serum specimens were collected at various intervals during the course of the pregnancy. In several instances the maternal antibody titer was determined at birth, the immunized status of the mother not having been previously recognized. Occasionally the first indication of the nature of the disease was recognized on the request for blood transfusion of the newborn infant. The procedures used in performing antibody titrations have been published elsewhere.[1] The practice of storing frozen specimens of serum withdrawn from the immunized mother during the course of her pregnancy has, more than any other single factor, led to consistency in antibody titrations. These specimens are restudied with later serum samples and serve as controls so that one may determine a definite change in antibody titer. Specimens of blood are studied within 24 hours after withdrawal, and the same red blood cells of known antigenic composition are used in all studies.

Infant Mortality Related to Maternal Antibody Titer

In spite of several excellent reports[2-4] on the relationship of concentration of the blocking variety of Rh antibody to the infant's disease, other reports indicate unreliability of maternal antibody level as a prognostic guide.

The relation of infant death to maternal antibody titer in 192 cases is shown in table 1. It will be noted that consistent mortality in infants appears only after the antibody titer has reached a level of 1:64, and that the mortality increases from this level upwards. Two deaths are recorded when the antibody titer was lower than 1:32, being 1:8 in both instances. These deaths are not explained by the data available since postmortem studies were not performed and laboratory data did not indicate severe anemia. There were 52 deaths in this series including 25 stillborn children. The mortality rate when the titer was less than 1:64 was 2.1 per cent. When the antibody

Associate Director, Blood Bank of Dade County, Inc., and Medical Research Foundation of Dade County, Inc.
Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 28, 1952.

titer was 1:64 or above, the mortality rate was 50.5 per cent. These figures indicate that the risk encountered by an Rh positive infant in an immunized mother is intimately related to maternal antibody titer.

Table 1.—Relation of Infant Death to Maternal Antibody Titer in 192 Cases; Last Prenatal Maternal Antibody Titer

	Trace-2	4	8	16	32	64	128	256	512	1024	2048 and Higher
Number	8	8	24	23	30	22	33	28	5	3	8
Deaths	0	0	2	0	0	4	14	19	4	3	6
		2/93=2.1%				50/99=50.5%					

Over-all mortality 52/192=27%
Excluding 25 stillborn deaths, per live child
27/167=16.1% mortality

Infant Morbidity Related to Maternal Antibody

Since anemia is a cardinal feature of the disease erythroblastosis fetalis, the necessity for blood transfusion is an accurate guide to the severity of the disease in a living child. The data presented in table 2 indicate that the need for transfusion was infrequent in cases in which the maternal antibody titer was 1:8 or less, but that it increased from this level upward. At a titer of 1:64 or higher, transfusion was indicated by the anemia and other manifestations of the disease present in every case.

Morbidity as represented by anemia requiring transfusion is intimately related to maternal antibody titer.

Table 2.—Relation of Maternal Antibody Titer to Need for Transfusion in 192 Cases

	Trace-2	4-8	16-32	64-128	256-512	1024 and Higher
Number	8	32	53	55	33	11
Living	8	32	53	46	21	7
Required transfusion	0	8	40	46*	21*	7*
Exchange performed	0	0	1	13	9	4

*Included are those dying before transfusion could be given.

Exchange Transfusion

Upon recognition of the relationship between maternal antibody and infant disease, indications for an exchange transfusion may then be established. The pathogenesis of erythroblastosis is the action of maternal antibody on fetal red blood cells. The maternal antibody crosses the placental capillary membranes and attaches onto specific antigens on the infant's red blood cells. The cells thus changed are more readily destroyed in the fetal tissues. The survival time of the red blood cells is probably inversely related to the amount of antibody fixed on them — the greater the amount of antibody the shorter the life of the cell. Anemia and the resultant anoxia lead to tissue damage. The compensatory efforts of the fetus to overcome the anoxia account for many of the features of this disease.

One is able by careful prenatal maternal antibody studies to establish the risk to which the infant is exposed. By prompt attention to the newborn infant, one may judge the need for transfusion and, in particular, the desirability of performing an exchange transfusion.

The removal of blood from an infant and its replacement with other blood was perhaps first performed by Hart[5] in 1925. Following the discovery and elucidation of the Rh blood factors, Wallerstein[6] specifically applied the procedure to erythroblastosis fetalis due to Rh incompatibility. Various technics have been developed by Wiener and Wexler,[7] Greenwalt,[8] Diamond,[9] Arnold and Alford[10] and others.

At the Blood Bank of Dade County the criteria for exchange transfusion in infants, based on laboratory procedures designed to measure the degree of damage caused by maternal antibody, are as follows:

1. The demonstration of human antibody fixed on the infant's red blood cells by the use of anti-human serum in the direct Coombs test. This test should be performed routinely on all specimens of blood sent to the laboratory with the request for transfusion of an infant in the first few days of life. Positive reaction to the test indicates that antibody is fixed on the cells of the child, shortening the life of the red blood cells in the infant's circulation. A quantitative estimation of the amount of antibody can be made with the slide test procedure which we employ at the Blood Bank of Dade County.[11]

2. The demonstration of anemia by an accurate red blood cell count and hemoglobin determination of the peripheral blood of the newborn infant. We have considered anemia to be moderate to severe with red blood cell counts below four million cells. This degree of anemia is usually associated with a strongly positive reaction to the Coombs test and with a maternal antibody titer in the range where mortality and morbidity are considerable. We have reserved all exchange transfusion procedures for such infants.

3. The demonstration of free antibody in the infant's serum. In our opinion the red blood cells of the infant will combine with maternal antibody to the degree that all red blood cell receptors for the antibody are completely satisfied. Frequently it will be found that considerable amounts of antibody remain free in the infant's serum. This is an indication that the red blood cells are heavily coated with antibody and are doomed to early destruction. In addition, the amount of free antibody present will be available for red blood cells which the infant may be able to produce so that the free antibody will further jeopardize the chances of survival of the infant.

4. Clinical manifestations of disease. The erythroblastotic infant may appear to be relatively normal at birth and within the course of the first few hours of life show rapidly progressing signs of anemia and jaundice. On the other hand, the infant may be pale and jaundiced at birth and show clinical signs of advanced disease as evidenced by bile staining of the umbilical cord, large liver and spleen, petechial hemorrhages, edema, and great lassitude. Clinical features are important in determining the severity of the disease. It is not infrequent, however, for the laboratory findings to disagree with the clinical impression shortly after birth. We have found that in instances in which the red blood cell count is low and the reaction to the Coombs test markedly positive, there is a rapid progression of the disease in spite of the early favorable appearance.

The laboratory procedures evaluating the infant's serologic status require at the most 15 to 30 minutes.

In accord with the criteria described, table 3 shows that exchange transfusions have been indicated and used only in infants of mothers with moderate or high concentrations of Rh antibody. Within any antibody titer grouping, individual variations of the severity of the disease are encountered, and in some of the cases, for example in the antibody level of 1:64, the infant may require only single or multiple transfusions; others may require exchange transfusions on the basis of the findings in the infant.

The purposes of the exchange transfusion are to:

1. Supply the infant the large amount of blood required to restore a normal red blood cell count and hemoglobin.

2. Remove red blood cells coated with antibody, thus relieving the infant of end products of cell destruction which otherwise must be handled by tissues already overburdened.

3. Remove the excess and free antibody which otherwise will be attached to and damage new red blood cells produced by the infant.

4. Shorten the illness of the infant by giving cells compatible with the antibody passively acquired from the mother. The large single transfusion will reduce the number of transfusions subsequently required. If large amounts of antibody are present in the infant's plasma, transfusions may be required at intervals for as long as three months.[12]

The Technic of Exchange Transfusion

At the birth of an infant expected to have erythroblastosis fetalis it is recommended that a sterile plastic catheter* be inserted into the umbilical vein without delay. The catheter may be fixed in position with hemostats and clamped off while the necessary laboratory work is being performed. If a simple transfusion or an exchange transfusion is required, no time will have been lost, since the route of administration has been secured. If no transfusion is deemed necessary, the catheter may be removed and the cord tied.

The umbilical vein is large and readily identified in the cut end of the cord. Its tortuosity often necessitates the removal of the cord to less than 1 inch from the abdominal surface. Patience is required to insert the catheter to such depth (usually 3 to 5 inches) that a free flow of blood is obtained. Varying the position of the vein and catheter, and often stretching the umbilical vein, will be necessary to pass the catheter until a free flow of blood is established. Once the inferior vena cava is reached, the return of blood from the catheter will be prompt. The catheter may be clamped with a hemostat until the transfusion is set up. A 16 gauge intravenous needle inserted into the distal end of the No. 16 catheter provides an excellent channel for the administration and the removal of blood.

Occasionally the umbilical vein will not be available because of its extreme tortuosity or the possibility of early thrombosis. The recommended alternate route is a superficial branch of the saphenous vein exposed by a surgical incision in the femoral region.[10] Here it is recommended that the smaller sterile plastic catheter No. 19 be used. The end of the catheter may be cut so that a long bevel is formed; a small incision into the wall of the vein will then allow the catheter to be

*Polyethylene catheters Nos. 16 and 19, sterile and ready for use were obtained from Dade Reagents, Inc., Miami, Fla.

advanced from 3 to 5 inches into the inferior vena cava. The catheter should be tied securely in the vein with ligatures. This route has proved highly satisfactory for exchange transfusion.

The blood transfused should be as fresh as possible. It must be compatible from the standpoint of blood group and it must be of an Rh type which will not react with the specific Rh antibody present in the child's circulation. Most often the antibody is anti-Rh_0 and the blood transfused must be Rh_0 negative. The blood must be proved compatible by accurate crossmatch.

Universal donor blood (Group O) must not be employed for exchange transfusion in babies who are A, B, or AB. Group O blood contains anti-A and anti-B antibody usually in moderately high titer, and the use of large volumes of blood, as required in exchange transfusion, will load the infant's circulation with anti-A and anti-B antibody, which may have a deleterious effect on the infant's own A, B, or AB cells.

The transfusion is given as follows: A three-way stopcock is connected to a needle placed in the end of the catheter. The blood transfusion and administration set is connected to another adapter on the stopcock, and a syringe is placed in the third adapter. The syringe is filled with blood from the bottle, and 20 to 40 cc. of donor blood is slowly injected into the infant before blood is withdrawn. This gives the infant a small positive balance of blood in the beginning. Following the administration of blood, 10 to 20 cc. of blood may be withdrawn and collected in a test tube for further laboratory studies if desired. The syringe is again filled from the blood bottle and injected slowly into the infant. Alternate injections of 10 to 20 cc. of donor blood and withdrawal of like amounts of infant blood are continued. A careful record should be kept of the amount of blood injected and the amount withdrawn.

In most cases the administration of 500 cc. of whole blood and the withdrawal of 400 to 450 cc. is adequate to correct the severe anemia of the infant. The blood volume of an infant may be calculated as being 40 cc. per pound of body weight. In an infant, for example, weighing 6 pounds, the blood volume is approximately 240 cc. The injection of 500 cc. of whole blood with the removal of 460 cc. would be equivalent to an exchange of slightly over two times the infant blood volume. This amount is usually adequate, and we have been successful in the management of 2 severely affected erythroblastotic infants with such transfusions.

Blood is injected and withdrawn at a rate of not over 10 cc. per minute. Overload reactions are rarely encountered. It is recommended that the infant be maintained at a desirable body temperature and given oxygen as required. During the exchange transfusion 1 cc. of 10 per cent calcium gluconate may be given intravenously as required. This is designed to combat a temporary calcium shortage although the citrate in the donor blood is usually rapidly metabolized.

Results of Exchange Transfusion

Table 3 summarizes the experience with exchange transfusion, multiple transfusion and no transfusion among infants of mothers whose titers were 1:64 and higher. It will be noted that 70 per cent of infants given the exchange transfusion survived, compared to 80 per cent survival in infants given multiple transfusions. It must be realized, however, that when multiple transfusions were given, the severity of the disease in the infants was less than when exchange transfusion was indicated. In 5 mothers having extremely high titers of antibody the only surviving children were 2 who received exchange transfusions. In 7 cases in which no transfusion was given due to the late recognition of the disease, there were no survivals in infants of mothers whose titers were above 1:64.

Table 3.—Management of Erythroblastosis Fetalis According to Maternal Antibody Titer

	64	128	256	512	1024	2048 and Higher	Totals
Live births	20	26	20	1	2	5	74
Exchange transfusion	5	8	9	1	1	3	27
Survived	4	7	5	1	0	2	19
Transfusion	14	15	9	0	1	1	40
Survived	14	13	5	0	0	0	32
No transfusion	1	3	2	0	0	1	7
Survived	0	0	0	0	0	0	0

It will be noted also in table 3 that stillbirths occur with increasing frequency in mothers with high antibody titers. This observation has led us to the recommendation, on the basis of prenatal antibody studies and past history of incompatible transfusion or erythroblastotic children, that early delivery be performed in an effort to salvage some of the children. It is usually found necessary to perform exchange transfusion in these cases.

Summary

Erythroblastosis fetalis is due to the action of specific maternal antibody on the red blood cells of the infant.

The greater the amount of maternal antibody, the graver the risk to the infant in utero.

The exchange transfusion is a safe and rational procedure and should be carried out on the basis of certain criteria herewith presented.

Exchange transfusion, performed according to the severity of disease in the infant, improves the chances of survival.

Early delivery will conserve the lives of certain infants.

References

1. Griffitts, J. J.; Elliott, J., and Cox, F.: Rh Antibody Titrations, Proceedings Third Annual Meeting American Association of Blood Banks, Chicago (Oct.) 1950, p. 121.
2. Davidsohn, I.: Rh Antibodies; Correlation with Clinical Findings, Blood, Spec. Issue No. 2:139-154 (Jan.) 1948.
3. Wiener, A. S.; Nappi, R., and Gordon, E. B.: Studies in Rh Sensitization. V. Importance of the Titer of Rh Antibodies in the Sensitized Pregnant Rh-Negative Woman for Prognosis, Am. J. Obst. & Gynec. 63:6-15 (Jan.) 1952.
4. Sacks, M. S.; Kuhns, W. J., and Jahn, E. F.: Studies in Rh-Isoimmunization in Pregnancy; Observations in Series of 96 Sensitized Women, Am. J. Obst. & Gynec. 54:400-414 (Sept.) 1947.
5. Hart, A. P.: Familial Icterus Gravis of New-born and Its Treatment, Canad. M. A. J. 15:1008-1011 (Oct.) 1925.
6. Wallerstein, H.: Treatment of Erythroblastosis Fetalis by Substitution Transfusion, Blood, Spec. Issue No. 2:170-179 (Jan.) 1948.
7. Wiener, A. S., and Wexler, I. B.: Use of Heparin When Performing Exchange Blood Transfusion in Newborn Infants, J. Lab. & Clin. Med. 31:1016-1019 (Sept.) 1946.
8. Greenwalt, T. J.: The Use of Red Cell Mass in Replacement Transfusions for Hemolytic Disease of the Newborn, Proceedings Third Annual Meeting, American Association of Blood Banks, Chicago (Oct.) 1950, pp. 139-155.
9. Diamond, L. K.: Replacement Transfusion as Treatment for Erythroblastosis Fetalis, Pediatrics 2:520-524 (Nov.) 1948.
10. Arnold, D. P., and Alford, K. M.: New Technique for Replacement Transfusion in Treatment of Hemolytic Disease of Newborn Infant, J. Pediat. 32:113-118 (Feb.) 1948.
11. Ellis, E.: A Slide Test Procedure Using Anti-Human Globulin Serum (Coombs Serum). To be published.
12. Griffitts, J. J., and Nock, W. S.: A Note on Persistence of Antibody Passively Transferred from Mother to Infant, Am. J. Clin. Path. 21:260-263 (March) 1951.

1800 N. W. Tenth Avenue.

Discussion

Dr. Lewis T. Corum, Tampa: I have enjoyed the fine presentation of Dr. Griffitts and I agree with his observations. I should like to stress the following points that Dr. Griffitts has presented, which I think are essential for the successful handling of cases of erythroblastosis:

1. The importance of following the Rh antibody titer throughout pregnancy. If this is done, one can anticipate with considerable certainty and security just what the problem will be at birth and can be prepared to carry out the necessary therapeutic procedures, namely, having on hand at the time of delivery a sufficient amount of Group O Rh negative blood to perform the transfusion. Sometimes it is rather difficult to find sufficient quantities of O Rh negative blood, particularly if one chooses to use female blood.

2. Laboratory personnel present to perform the following tests, which are necessary for the diagnosis:

A. Direct Coombs test
B. Hemoglobin and red blood cell determination
C. Rh determination
D. Icteric index

3. Equipment and personnel available for carrying out the procedure, which, along with teamwork, is essential for a successful transfusion. For the six exchange transfusions we have performed in the past year, a team of five persons has been required, two doctors and three nurses, all of whom have been well oriented in the procedure. You cannot go over to the hospital, pick up an intern and two or three nurses who have never seen the procedure before and carry it out well.

In considering the advisability of early induction, one must weigh the dangers of prematurity against the possible damage that might be done to the infant by the continued action of the maternal antibody during the last three or four weeks.

In closing, I should like to ask Dr. Griffitts about the measurement of venous pressure during the transfusion, as has been advocated by others.

Dr. Lynn W. Whelchel, Miami: We have been most fortunate to have Dr. Griffitts give this paper on a subject which is of such importance to anyone having anything to do with obstetrics and pediatrics. In Dade County we usually take Dr. Griffitts as a matter of course and do not appreciate what we have, or rather do not stop to realize his help to us.

The pediatricians in this county, however, do recognize the value of his work and appreciate the help that he gives each individual when he has a problem of erythroblastosis. The reason I say that the profession as a whole fails to give him his just due is that we still have many newborns delivered in Miami for whom a call is put through to the pediatrician to come immediately to see the baby with whom there is something the matter. When the pediatrician arrives and evaluates the situation, he in turn puts in an urgent call for Dr. Griffitts. Studies are then initiated at this late date when they should have been in progress for many months previously.

While the pediatricians do appreciate the help offered, we do not believe that the problem is at all simple or that it is nearly solved. All of us have had cases of erythroblastosis in which, clinically, we thought the infant would do well, but from the laboratory findings we discover that there are great difficulties in store for the baby. Some of the babies on whom we have initiated an exsanguination transfusion die during the procedure or immediately afterwards. We cannot help but think that maybe we were wrong in undertaking the exsanguination transfusion, that the whole story has not been answered by the laboratory tests and, possibly, that the exsanguination transfusion is not without some danger in itself. Of course there are many cases in which the procedures to be carried out are definitely made clear by the laboratory findings and a great number of babies are saved, but we are always hoping to find methods to save many more.

In the discussion of the technic, I should like to stress again most strongly that one is dealing with newborn and frequently premature infants and that all precautions protecting the vital functions of these infants should be meticulously carried out during the time of study and during and following the transfusion. Nothing is gained by the transfusion if the baby succumbs from some other cause.

Dr. Griffitts: I want to thank the discussants, Dr. Corum and Dr. Whelchel. In answer to Dr. Corum's question about venous pressures, we have not made any observations although it would be extremely interesting and easy to do. We will try to add that to our studies. It might be a way in which one might relieve himself of the anxiety of thinking that maybe he had overloaded the infant, because a definitely increased venous pressure at any time in the procedure could be rapidly corrected, if it were an overload, by withdrawing blood.

Dr. Whelchel's concern about whether or not exsanguination transfusion should be carried out is warranted. Time did not allow to paint all the different shades of gray between white, when we do not have to transfuse, and black, when we know we have to transfuse. Biologic studies or studies of a living animal are fraught with all sorts of variables. We are certain that when the titer is high, we will encounter infant disease and have to treat it. To make a decision whether to perform an exsanguination transfusion, or simply to give the child a small transfusion and repeat it as necessary, is sometimes difficult. Personally, I tend to err a bit on the side of performing the exchange transfusion procedure. If one performs a single transfusion and then loses the baby, he will always have the question of whether he should have performed an exchange transfusion. The art of medicine is long.

Volume XXXIX
Number 4

Acute Craniocerebral Injuries

James G. Lyerly, M.D.
Jacksonville

Patients with acute injuries of the skull and brain continue to be admitted frequently to every hospital where emergency cases are treated. The physicians on the staffs of such hospitals will be called on to treat these patients. Since a neurosurgeon will not be available, the general surgeon and family physician will be called on to treat them. There will be complications and associated injuries, which will require the services of specialists in every field of medicine. This subject should be of interest, therefore, to everyone present at this meeting.

Vital Signs

Whenever a patient is admitted to the emergency room of a hospital, one tries to determine his general condition and estimate the extent and degree of the injury. Frequently shock is not present unless the patient has associated injuries such as fractures of the extremities or spine, or severe thoracic and abdominal injury. Blood pressure, therefore, may be maintained at a normal level. With injury of vital centers, as the medulla or the brain stem, there may be a falling or lowered blood pressure. The state of consciousness may help to determine the severity of the brain injury. Also, the duration and degree of unconsciousness may have a bearing on the severity of the injury to this organ. With deep coma, when the patient cannot be aroused by any type of stimulation, there is probably a severe degree of brain injury. The size and reaction of the pupils are important, and a dilated, fixed pupil with deep coma probably represents a fatal injury. Pinpoint pupils with unconsciousness usually mean injury of the brain stem. A disturbance of the respiratory rate and rhythm with Cheyne-Stokes breathing probably means a severe or fatal brain injury. The same is true of a falling blood pressure with a rapid pulse rate. A subnormal temperature at first is expected, but within an hour or two the temperature rises, and a hyperthermia may develop with a severe and fatal injury.

Diagnostic Signs

Unconsciousness

Unconsciousness or amnesia of less than fifteen minutes' duration usually is associated with mild concussion of the brain. Of longer duration, for hours or days, it means a more severe brain injury. A patient is semiconscious when he can be aroused or move his extremities, while coma means no response to stimulation. A period of amnesia with apparent consciousness and a normal conversation may exist, and it may last for a considerable time. A retrograde amnesia may exist for a time prior to the accident.

Laceration and Contusion of the Scalp

A laceration of the scalp will locate the blow and aid in the examination for a fracture of the skull. Contusion of the scalp with hematoma beneath the pericranium may show a fluctuant swelling in the center with a raised ridge around the margin due to blood clots beneath the pericranium. This condition will give one a false impression of a depressed fracture of the skull.

Bleeding or Leaking Spinal Fluid from Ear and Nose

Bleeding from the ear, especially if there is spinal fluid escaping, means fracture of the middle fossa of the skull. Bleeding from the nose with escape of spinal fluid means fracture of the anterior fossa.

Pupillary Size and Reaction

A pupil of large size with reaction to light has little significance. A dilated, fixed pupil associated with other vital signs, however, may be of serious omen. Inequality of the pupils is of importance since a localized hemorrhage of the brain causing compression may produce a dilated, fixed pupil on the same side. This is so often seen with extradural and subdural hematoma.

Presented at the Atlantic Coast Line Railway Surgeons Meeting, Charleston, S. C., Jan. 24-25, 1952.

Chief of the Department of Neurological Surgery, Duval Medical Center, St. Vincent's Hospital, St. Luke's Hospital, Brewster Hospital and Hope Haven Hospital, Jacksonville.

Cranial Nerves

Paralysis of the third cranial nerve will produce a dilated, fixed pupil, ptosis of the upper lid and extraocular paralysis except for downward and outward rotation of the eye. Paralysis of the sixth cranial nerve will cause an internal squint and signify an injury at the base of the skull. The seventh, or facial, nerve is frequently paralyzed by fractures in the middle ear and of the temporal bone. The facial paralysis will be of the peripheral type with all branches being involved. Injury to the optic nerve may be due to fracture through the optic foramen and may result in blindness. In such case, one should employ roentgenograms to rule out a depressed fracture of the optic foramens.

Paralysis

Paralysis or weakness of the extremities and of the lower part of the face may be associated with a severe brain injury. With an unconscious patient, one may obtain evidence of paralysis by observing the extent to which the face and extremities are moved by supraorbital pressure.

Reflexes

A hyperreflexia will be associated with a paralysis, but it must be borne in mind that with acute cerebral lesions due to trauma, especially while shock is still present, the reflexes may not be exaggerated. One expects to find the reflex involvement varying from a Babinski, Oppenheim or Gordon reflex to an ankle clonus on the side opposite the lesion and on the side of paralysis.

Convulsions

Convulsions do not occur frequently in the early stages of brain injury. Should a patient have a low convulsive threshold, however, it is not unusual for a convulsion to be associated with a slight blow on the head with mild concussion. On the other hand, should there be severe cortical brain injury with hemorrhage, either extradurally or subdurally, there may be a jacksonian convulsion. Likewise, a convulsion may be associated with a depressed fracture of the skull with an injured brain cortex, especially when it is near the motor area. When one sees convulsions in the early stages of brain injury, one should bear in mind that this condition may plague the patient for the rest of his life, and he will require adequate therapy to prevent the seizures after he has made an immediate recovery.

Blood Pressure, Pulse and Respiration

With increased intracranial pressure developing from an extradural hemorrhage or an acute subdural hematoma, there are apt to be changes in the blood pressure, pulse and respiration. For that reason they should be recorded every thirty minutes to an hour during the early stages of observation. Before the systolic pressure rises in acute intracranial pressure, there is likely to be a drop in the diastolic pressure. This gives an increase in the pulse pressure. Later on, the systolic pressure rises when the intracranial pressure exceeds that of the arterial pressure in the medulla. The pulse rate drops with increasing intracranial pressure as occurs with an extradural hemorrhage, and a pulse rate of 40 or 50 is not unusual. Should there be associated injuries, however, a slow pulse rate may not occur. The respiratory rate may not be seriously involved except in severe fatal injuries and in the late stages of increased intracranial pressure.

Hyperthermia

In severe brain injury there may be an elevation of temperature of 106 F. or more. It is a serious mistake to allow the temperature to go higher because of the damage to the brain cells. It may be reduced by bathing with tepid or cool water, by applying ice caps about the body and by an electric fan blowing on the patient's head and front part of the body. The patient should not be covered with bed clothes other than a sheet, and the use of blankets should be condemned.

Rigid Neck

In head injury, especially with the blow being received in the frontal region, there may be a fracture or dislocation of the cervical spine. Roentgenograms of the neck should be included in the examination. A stiff neck, however, is frequently associated with head injury without injury to the vertebra. It may be due to subarachnoid hemorrhage or increased intracranial pressure.

Spinal Puncture

Examination of the spinal fluid is not a routine measure. It should be avoided in the early stages until the patient's condition has been more definitely established, and a localized hematoma has been ruled out. Should the patient, however, be extremely restless with a stiff neck and signs of subarachnoid hemorrhage, a spinal puncture may be of definite therapeutic value. When a spinal puncture is performed, the pressure should be re-

corded because it may give evidence of the degree of intracranial pressure, provided there is no blockage at the foramen magnum or of the ventricular system. Spinal puncture should be contraindicated when there are signs of localized hematoma, as extradural hemorrhage, since the reduction of pressure would increase the formation of the clot and increase the brain compression. A spinal puncture should not be performed in the presence of bleeding or leaking spinal fluid from the ears or nose because of the danger of reversal of the circulation from the contaminated area to the spinal fluid spaces, for fear of producing a meningitis.

Roentgen Examinations

An emergency roentgen examination is seldom indicated in the treatment of injuries of the skull and brain. Should there, however, be a question of a depressed fracture of the skull, it may be made on admission of the patient to the hospital. It may be of aid in diagnosing an extradural hemorrhage when a fracture line crosses the groove of the middle meningeal artery. With these exceptions, an emergency roentgenogram is of doubtful value except to satisfy the curiosity of the physician and of the family. It is useless to make a roentgen examination of a patient who is unconscious and restless when his condition is of such serious nature that it probably will be fatal in a short time. Roentgen examination of a restless, semiconscious patient is of little value because of the poor quality of the picture, and the mere demonstration of a linear fracture would not change the method of treatment. Frequently roentgenograms of the skull are made some days after the injury, depending upon the patient's condition. On roentgen examination, one should look for displacement of the pineal body, because a localized compression from subdural or extradural hemorrhage may displace it to the opposite side.

Treatment

General Care

The emergency room treatment should take care of the immediate needs of the patient and treatment for shock, should it be present. This may require intravenous fluids, plasma or blood transfusion. Lacerations of the scalp may be treated by shaving the head, excision of the ragged, contused edges under local anesthesia and suturing the lesion as an incised wound. If the blood pressure is low and severe shock is present, the repair of the wound should be postponed until a later date. With respiratory difficulty and secretions in the tracheobronchial tree, the patient should be placed in a face down side position with the bed flat, or the foot of the bed elevated to give postural drainage. This position should be maintained as long as the patient remains unconscious and has respiratory secretions in the throat. Should the patient be conscious and more comfortable with an elevation of the head, the back rest may be raised 20 to 30 degrees.

A fluid intake of 2,000 cc. a day is usually adequate, consisting of 1,000 cc. of 5 per cent glucose in normal saline alternating in distilled water every twelve hours by vein. If there are associated injuries of the chest or abdomen or fractured extremities, the fluid intake may be increased to 3,000 cc. a day. It is believed that this amount of fluid intake is adequate to support the patient's general physical needs, and it will not contribute to swelling and edema of the brain. I do not use other dehydrating measures, as solutions of hypertonic glucose, sucrose and magnesium sulfate intravenously, unless there is extreme emergency of relieving intracranial pressure while the operating room is being prepared. I prefer hypertonic sucrose over glucose because of the absence of reversal edema obtained with the latter. Nourishment may be given by nasal tube, with the same amount of fluids of adequate caloric value as mentioned. Intravenous fluids, however, are usually given the first few days with bleeding from the nose and the presence of a considerable amount of mucus in the throat.

Restlessness may be present in a semiconscious patient with a full bladder and with painful areas about the body. Restraints of the body and extremities may increase the restlessness and physical exertion to the point of exhaustion. In order to protect the unconscious patient from falling out of bed and further injuring himself, side boards or rails should always be applied to the bed. Sedation must be used to prevent extreme restlessness and possible exhaustion. In my opinion the best sedative is paraldehyde given by mouth through the nasal tube or by rectum. The barbitals, as phenobarbital sodium given hypodermically, may be used. I prefer not to use opiates unless the patient has associated fractured extremities or severe injury of the chest. In this case I prefer codeine, grains ½, and/or aspirin, grains 10, as needed. Morphine or demerol should be used as a last resort. Opiates have a tendency to depress the respiratory centers, and in severe brain injury

with intracranial pressure the use of them may be fatal.

For a full bladder it is believed that an indwelling plain tip catheter is the best method of treatment. This may relieve the extreme restlessness and keeps the bed dry, aiding in the nursing care of the patient. With the indwelling catheter some form of tidal drainage with continuous bladder irrigation is preferred.

Surgical Treatment

Depressed Fractures of the Skull

Depressed fractures of the skull may be simple or compound. The simple depressed fracture may not require operation as an emergency measure; several days can be allowed to observe the patient's general condition before the operation is performed. Any material depression over important brain centers should be operated on and the depressed fracture elevated to prevent further injury to the brain. Slight depressed fractures over the longitudinal or lateral sinus may be left undisturbed.

Compound depressed fractures of the skull which are frequently comminuted should be operated on as an emergency measure, preferably during the first eight to sixteen hours. Sometimes, with the poor condition of the patient and with adequate chemotherapy, the operation may be postponed twenty-four hours. The indications for the operation are the prevention of infection and the removal of depressed fragments of bone. The blood clots and loose fragments of brain tissue should be removed; then should follow the repair of the dura, which is sutured tightly. The fragments of depressed bone are elevated, and should some of them become detached, they may be replaced in the defect as a graft to fill in the cranial defect. This procedure makes unnecessary at a later date a cranioplasty with the use of a metal plate, which is never as satisfactory as a true bone graft. It is extremely important that the dura be sutured tightly, and should there be a loss of the dura, some temporal muscle fascia or fascia lata may be used as a substitute for the repair. Should the dura not be sutured tightly, the swelling and edema of the brain may force cerebral tissue through the defect and open the scalp wound, producing a brain fungus. This would be a serious complication leading to brain abscess, encephalitis, meningitis and loss of brain tissue, all of which may be fatal. Furthermore, hospitalization would be greatly prolonged because of the delayed healing of the wound.

Extradural Hemorrhage

As soon as the diagnosis of an extradural hemorrhage has been made, an emergency operation should be performed. There is no more extreme emergency in the management of head injuries than that of an acute extradural hemorrhage when a patient may die within a few hours from the time of the injury unless surgical treatment is promptly rendered. At operation the hemorrhage is usually found in the temporal region resulting from the tear of one of the branches of the middle meningeal artery. At times the hemorrhage appears to arise from some of the veins in the neighborhood of the longitudinal or lateral sinus. The operative procedure consists of a drill hole in the temporal region to locate the hemorrhage. Then a small osteoplastic flap is turned down over it for the purpose of removal of the clots and control of the bleeding vessels. After control of the bleeding vessels with electrocoagulation, silver clips, suture or gelfoam, the bone flap is replaced. The advantage of the bone flap is an adequate exposure and the maintenance of the cranial contour after the operation, which is not the case with a subtemporal craniectomy.

Subdural Hematoma

Subdural hematoma may produce the same symptoms and findings as extradural hemorrhage except for the later period of development of several days, and in the case of chronic subdural hematoma it may be weeks or more in coming on. In the case of acute subdural hematoma, usually there is severe contusion and laceration of the brain with unconsciousness from the beginning of the injury, so that the lucid intervals may not be present. With the signs of increased intracranial pressure and a deepening coma, with or without localizing signs, one should consider the possibility of an intracranial hematoma of some type which may require surgical removal. Should there be any doubt of the diagnosis, it is better to make drill holes in both upper temporal regions under local anesthesia to give surgical relief of the hematoma. Sometimes the hematomas are liquid and may be washed out and drained by a catheter, with the use of Ringer's solution. Solid clots may require an enlarged opening or even an osteoplastic flap for their removal. Drill holes may be required in the frontal and occipital regions to aid in the removal when the hematoma extends away from the temporal region. It is better to make drill holes on both sides, especially in chronic subdural

hematoma because of the frequency of the condition on both sides.

Cerebrospinal Rhinorrhea

Leakage of spinal fluid from the ear seldom requires a surgical procedure since it stops of its own accord in a few days. A sterile dressing on the external ear after cleansing with alcohol is all that is required. The external auditory canal should not be plugged up with a packing or with cotton. Chemotherapy with penicillin, sulfadiazine or other antibiotics should be used to lessen the danger of meningitis.

Cerebrospinal rhinorrhea, or the leakage of fluid from the nose, is a more serious complication, and a pyogenic meningitis is apt to develop should the drainage exist over a long period of time. With conservative measures it may stop of its own accord when the opening in the dura is small. To facilitate this stoppage, the patient's head should be elevated on the back rest at an angle of 30 to 45 degrees. The patient should be instructed never to blow his nose, and no sprays nor irrigations in the nasal cavity should be permitted. A spinal puncture should not be performed unless there are definite signs of meningitis, and the leakage of fluid from the nose has stopped, when it may be carried out to determine the type of meningitis.

Should conservative measures fail after one or two weeks, surgical treatment may be used to prevent meningitis. This requires turning down a frontal osteoplastic flap, lifting up the frontal lobe and sewing up the tear in the dura, or repairing the hole with muscle or fascia graft to stop the fluid leakage.

Edema of the brain without hematoma or other form of compression does not require surgical treatment. The old subtemporal decompression for edema of the brain has been discarded. It is doubtful that any surgical measure used today will adequately relieve this form of increased intracranial pressure. Moderate dehydration with limitation of fluid intake, elevation of the head to encourage venous drainage and the maintenance of a free respiratory airway with the administration of oxygen are the principal points in its management.

Convalescent Care

With the regain of consciousness and other evidence of beginning recovery, the head of the patient should be elevated on a back rest preparatory to assuming an erect posture within a week or two. The vasomotor system in the brain, as well as the brain itself, has been injured, and getting the patient up gradually will lessen certain symptoms of vasomotor instability, dizziness, headaches and fainting. It is not necessary to keep the patient in bed for a long period of time. I usually get the patient up within a week or ten days after he becomes symptom-free. With early ambulation the period of convalescence may be shortened and return to employment of light nature will be encouraged.

References

Meredith, J. M.: Surgical Aspects of Acute Head Injuries, Surg., Gynec. & Obst. 93:297-302 (Sept.) 1951.

Segerberg, L. H., and Spurling, R. G.: Acute Craniocerebral Trauma: Essential Considerations of Diagnosis and Treatment, J. A. M. A. 141:371-376 (Oct. 8) 1949. Correction 141:613 (Oct. 29) 1949.

Segerberg, L. H., and Spurling, R. G.: Symposium on Recent Advances in Surgery; Acute Craniocerebral Trauma, S. Clin. North America 29:1301-1315 (Oct.) 1949.

Walker, A. E.: Practical Considerations in the Treatment of Head Injuries, Neurology 1:75-84 (Jan.-Feb.) 1951.

514 Greenleaf Building.

The Scientific Department of The Journal

Reflects the Experience of You and Your Colleagues

"Coronary Disease" of the Inner Ear: The Vascular Origin of Vertigo and Deafness

Jerome A. Hilger, M.D.
St. Paul

There is a purpose in drawing an analogy between disorders of the coronary artery and those of the labyrinthine artery of the inner ear. Those who practice in the field of general medicine know a great deal about the coronary artery, its distribution, its disordered function and diseases, and the cardiac disturbances which result. On the other hand, there is too little general knowledge of the same phenomena in the labyrinthine artery and the consequent disturbances in the inner ear. This lack is unfortunate because in clinical medicine vascular inner ear disturbances are at least as common as vascular cardiac disturbances. General ignorance of their meaning denies to these disorders the right of early recognition and treatment. In consequence, in the special field of otology we are too frequently dealing with residual vascular inner ear neural damage in the form of irreversible hearing loss or intractable vertigo, the origin and early phase of which were neglected. In otology we cannot help but feel our guilt. We have not carried a clear message to the general practitioner of medicine about the meaning of tinnitus and early hearing impairment and of initial vertigo, or of the need for their early treatment and of the inevitable end result of neglect in terms of permanent inner ear destruction.

Two important differences between the coronary artery and the labyrinthine artery must be held in mind. Both differences have to do with the end organ they supply:

1. There is a broad spectrum in the work load of the heart and, hence, in its arterial demands on the coronary artery. It varies from the coronary load at complete body rest to the load borne under the most violent body stress. The work load of the cochlear and vestibular end organs of the inner ear and their consequent demands on the labyrinthine artery do not vary significantly in this same sense.

2. The structures of the heart supplied by the coronary artery have none of the functional delicacy which characterizes the neural end organs of hearing and balance in the inner ear. As a result, a vascular change in the cardiac muscle may produce no symptoms while change of equal degree in the labyrinth may be violently expressive in terms of vertigo and/or tinnitus and hearing impairment. By this token the labyrinthine artery may be looked upon as a much more refined indicator of vascular function than is the coronary artery. Exception to this generalization may conceivably be made in the case of the coronary branches to the atrioventricular bundle. Here, in this specialized tissue, one can visualize alteration of conduction and cardiac rhythm in response to similar degrees of vascular change. Excepting those coronary terminals, however, one can appreciate the labyrinth arterial ramifications as more exact indicators of vascular function than comparable coronary branches.

Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 28, 1952.

Vascular Dysfunction

Accent is placed in the foregoing statement on vascular function in a broad sense. Vascular function has a pattern and sameness which is system-wide — not restricted to single organs. Differences lie only in the organs supplied. It must be appreciated that vascular disorder, wherever it may occur, is more frequently a factor of vessel dysfunction than of vessel disease. Pathology has dominated medical teaching for so long that present day awareness and accent on physiology and normal and disordered function is thought of as something new in medicine. It, of course, is not. Disease process has always had its first phase in disordered function and its final phase in pathologic change. The inner ear, being graced or cursed with end-circulation without collateral and neural structures of exceeding delicacy, is a clinical paradise for the study of vascular pathophysiology.

There is no pathologic change in the coronary tree that cannot be found in the branches of the labyrinthine artery. The destructive changes in

the end organs of hearing and balance that result from progressive occlusion of labyrinthine arterial branches are expressed in progressive increase in tinnitus, hearing impairment and vertigo. The changes that result from sudden occlusion, as from thrombus or embolus are cataclysmic in terms of roaring tinnitus, severe deafness and violent vertigo. Studies have shown, however, that inner ear destructions are more frequently due to vascular dysfunction than to these vascular occlusions.

The vascular system in any organ exists that its capillaries can be constantly perfused with circulating blood. The endothelium of the capillary is the exchange barrier between the blood and the dependent tissue. The endothelium is the first tissue cell affected by changes in the blood or alterations in circulation. When this living and semipermeable membrane is damaged, a sequence of misfortune is set in motion — transudate, stasis, hypoxia and peripheral tissue cell starvation. It is this sequence that produces tinnitus and hearing impairment through damage to the cochlear ganglion cells and the neuroepithelium of Corti's organ; and vertigo through damage to the vestibular ganglion cells and the neuroepithelium of the vestibule and semicircular canals. There is a distinctive end vessel distribution in the inner ear. Due to it, certain symptom variations can arise from the end organ. Unfortunately, these variations have been subjected to the common tendency of grouping as syndromes and designation as distinct diseases. Hence, a large variety of symptom complexes have become familiar to you under various headings, as Menière's disease; pseudo-Menière's disease; catarrhal deafness; eighth nerve neuritis; endolymphatic hydrops; labyrinthitis; labyrinthosis, and others. These are not specific and distinct diseases in the true sense. They are symptomatic disorders of vascular dysfunction (in the broad meaning) in an end organ capable of symptom variation due to peculiarities of its anatomy.

Knowledge of vascular dysfunction to a great extent hinges on knowledge of capillary endothelium. The integrity of the endothelium depends upon numerous known and unknown factors. The components of the blood and the adequacy of its circulation through the arteriolar-capillary-venular loop are the factors to which the endothelium is immediately responsive. Once the endothelium is damaged and transudate made easy, characteristics of the extravascular tissues themselves can aid in formation of edema. This is most graphically demonstrated in the retention of extravascular fluid due to unusual concentration of sodium. Its limitation can accordingly have a favorable influence on the undesirable stasis.

The components of the blood known to be important to the endothelium are:

1. The hemoglobin, the principal transport of oxygen vital to the endothelium and to the dependent tissue cells.

2. Certain vitamin catalysts — principally C and probably some B factors.

3. Certain hormones in balanced quantity — principally thyroid and the gonadal secretions.

4. The normal carbohydrate-protein-fat vital to every living cell.

Certain substances in the blood are, with cause, suspected as essential to endothelial function:

1. The adrenocortical hormone now related to the collagen diseases which, in reality, are first transudate diseases.

2. The trace minerals. Their importance is the subject of much current investigation.

The circulation of these elements through the capillary loop is subject to many interruptions. Any halt or delay in their continuous supply to the endothelium can damage the latter and contribute thereby to starvation of the end organ cell. Circulatory interruption may be due to block at the venous or arterial end. In the inner ear venous obstruction is not common. Large and small arterial obstruction due to intimal disease change is, as has been said, as common in the labyrinthine arterial tree as in the coronary. The gradual or sudden starvation of the peripheral capillary endothelium and end organ tissues results in progressive or total inner ear symptoms. Most frequently, however, it is not disease of the arterial walls that causes interruptions to the arterial blood flow, but rather functional obstructions at the arteriolar sphincter level. This sphincter in its widespread distribution through every organ and tissue in the body is the most important smooth muscle in the vascular system. Those factors which cause its sphincteric contractions are the source of arterial obstruction as definite and symptom-producing as atherosclerotic disease and much more common. The factors are principally of two kinds:

1. Direct neural impulsion through autonomic innervation of the arteriolar sphincter. These result from direct central nervous stimulation from the psychic areas most peculiar to man acting through the basal ganglia. Through this direct

neural chain emotional activity can affect arteriolar behavior anywhere in the body. The labyrinthine arterial terminals are commonly thrown into sphincteric spasm by it. The same sequence can derive reflexly from body surface receptors as through chilling or barometric pressure variations.

2. Antigen-antibody influence. Due to previous sensitization of the arteriolar smooth muscle in a so-called shock organ, a state of hypersensitivity is established in it due to antibody association with the muscle. This is prone to happen to the person called "allergic" in the narrow sense of the word. On subsequent re-exposure to the specific antigen, there is antigen-antibody union at the sphincter with resultant injury and spasm.

The end result of these spasmodic interruptions of arteriolar circulation in terms of endothelial damage and end organ stasis, hypoxia and starvation causes, in the inner ear, variations in the symptoms of tinnitus, hearing impairment and vertigo which collectively constitute those many symptom complexes which, by their separation into syndromes and diseases, have brought confusion and poor understanding. I leave it to your imagination to formulate what these same changes at the functional endothelial level in the many other organs and tissues with which you deal produce in terms of symptoms and eventual tissue degeneration, whether in the brain, the joints, the kidneys, the eye, the nose, the intestine, the skin or other organs.

Problem of Diagnosis

It must be apparent, therefore, that the patient who presents the inner ear symptoms of tinnitus, hearing impairment and vertigo in any variation of degree and association should be credited with having an interesting medical problem. Proper differential examination should be directed to the exclusion of occasional intracranial cause due to involvement of central pathways. Since the cochlear and vestibular central pathways diverge, the association of hearing symptoms with vertigo affixes the disturbance in the end organ. The solution of the vascular inner ear problem necessitates an analysis of those factors which can interrupt circulation and of those factors which can primarily cripple the endothelium or a combination of both factors which do commonly co-exist.

Vascular obliterative disease is not uncommon. Vasomotor irregularity in response to physical receptors or emotional reaction is more common. The two not infrequently occur in the same patient. The antigen-antibody conflict of allergy in the narrow sense is only an occasional disturber. The inner ear is not often its shock organ. Inner ear manifestations of endocrine imbalance are commonplace. Hypothyroid states of moderate degree and gonadal problems of premenstrual, pregnant and climacteric nature all can result in easy transudation into the confined inner ear with consequent disability. With increase in our knowledge additional factors will be identified. The particular fundamental problem at hand must be corrected before the essentials of nutrition in a properly nourished person can be made available to the end organ tissues themselves.

Correct treatment is always a factor of etiology. The solution of the vascular disorders of the inner ear and the resultant tinnitus, hearing impairment and vertigo is not a matter of formula but of diagnosis.

444 Lowry Medical Arts Building.

SIXTH ANNUAL CLINICAL SESSION — AMERICAN MEDICAL ASSOCIATION

DENVER, COLORADO DECEMBER 2-5, 1952

PRECEDED BY

MEDICAL PUBLIC RELATIONS CONFERENCE

DECEMBER 1

FLORIDA MEDICAL ASSOCIATION

OFFICERS AND COMMITTEES

OFFICERS

ROBERT B. MCIVER, M.D., President.....*Jacksonville*
FREDERICK K. HERPEL, M.D., Pres.-elect..*West Palm Beach*
FRANCIS H. LANGLEY, M.D., 1st Vice Pres...*St. Petersburg*
ERASMUS B. HARDEE, M.D., 2nd Vice Pres.....*Vero Beach*
H. QUILLIAN JONES, M.D., 3rd Vice Pres.....*Fort Myers*
SAMUEL M. DAY, M.D., Sec'y-Treas.....*Jacksonville*
SHALER RICHARDSON, M.D., Editor.....*Jacksonville*

MANAGING DIRECTOR

STEWART G. THOMPSON, D.P.H.....*Jacksonville*
ERNEST R. GIBSON, Assistant.....*Jacksonville*

BOARD OF GOVERNORS*

ROBERT B. MCIVER, M.D., Chm...(Ex Officio).*Jacksonville*
JAMES L. BORLAND, M.D...AL-53.....*Jacksonville*
DUNCAN T. MCEWAN, M.D...B-53.....*Orlando*
JAMES H. POUND, M.D...A-54.....*Tallahassee*
NORVAL M. MARR, M.D...C-55.....*St. Petersburg*
JOHN D. MILTON, M.D...D-56.....*Miami*
HERBERT E. WHITE, M.D...PP-53.....*St. Augustine*
DAVID R. MURPHEY, JR., M.D...PP-54.....*Tampa*
FREDERICK K. HERPEL, M.D. (Ex Officio).*W. Palm Beach*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*
HERBERT L. BRYANS, M.D...S.B.H.-53.....*Pensacola*
STEWART G. THOMPSON, D.P.H. (Advisory)...*Jacksonville*

*SUB-COMMITTEES

1. Veterans Care
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
GEORGE M. STUBBS, M.D.....*Jacksonville*
DOUGLAS D. MARTIN, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

2. Advisory to National Foundation Infantile Paralysis
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
H. PHILLIP HAMPTON, M.D.....*Tampa*
ROBERT P. KEISER, M.D.....*Coral Gables*
RICHARD G. SKINNER, JR., M.D.....*Jacksonville*

3. Review of Fee Schedules
JOHN D. MILTON, M.D., Chm.....*Miami*
WOODROW B. ESTES, M.D.,.....*St. Petersburg*
FREDERICK H. BOWEN, M.D.....*Jacksonville*
ODIS G. KENDRICK, JR., M.D.....*Tallahassee*
JAMES B. GLANTON, M.D.....*Orlando*
FLOYD K. HURT, M.D.....*Jacksonville*
HERSCHEL G. COLE, M.D.....*Tampa*
A. FRANKLIN HARRISON, M.D.....*Madison*
JACK O. W. RASH, M.D.....*Miami*
KENNETH S. WHITMER, M.D.....*Miami*
ADELBERT F. SCHIRMER, M.D.....*Orlando*

4. Blue Shield
LEIGH F. ROBINSON, M.D., Chm.....*Fort Lauderdale*

SCIENTIFIC WORK

JAMES N. PATTERSON, M.D., Chm...AL-53.....*Tampa*
CAROL C. WEBB, M.D...A-53.....*Pensacola*
FREDERICK K. HERPEL, M.D...D-54.....*West Palm Beach*
JERE W. ANNIS, M.D...C-55.....*Lakeland*
RICHARD C. CUMMING, M.D...B-56.....*Ocala*

LEGISLATION AND PUBLIC POLICY

H. PHILLIP HAMPTON, M.D., Chm...B-53.....*Tampa*
WILLIAM M. ROWLETT, M.D...AL-53.....*Tampa*
DANIEL A. MCKINNON, M.D...A-53.....*Marianna*
ANGUS D. GRACE, M.D...C-55.....*Fort Myers*
DONALD W. SMITH, M.D...D-56.....*Miami*
ROBERT B. MCIVER, M.D. (Ex Officio).....*Jacksonville*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*

MEDICAL EDUCATION AND HOSPITALS*

JACK Q. CLEVELAND, M.D., Chm...AL-53.....*Coral Gables*
JULIUS C. DAVIS, M.D...A-53.....*Quincy*
ELBERT MCLAURY, M.D...D-54.....*Hollywood*
S. CARNES HARVARD, M.D...C-55.....*Brooksville*
BENJAMIN F. DICKENS, M.D...B-56.....*Fernandina*

*SPECIAL ASSIGNMENT

1. Urge Gifts to American Medical Education Foundation

PUBLIC RELATIONS*

EUGENE B. MAXWELL, M.D., Chm...AL-53.....*Tampa*
LEIGH F. ROBINSON, M.D...D-53.....*Fort Lauderdale*
HOWARD V. WEEMS, SR., M.D...C-54.....*Sebring*
EUGENE G. PEEK, JR., M.D...B-55.....*Ocala*
HENRY L. SMITH, JR., M.D...A-56.....*Tallahassee*

*SPECIAL ASSIGNMENTS

1. Rural Educational Program
2. State Education Campaign

NECROLOGY

ALVIN L. STEBBINS, M.D., Chm...A-56.....*Pensacola*
HUGH WEST, M.D...AL-53.....*DeLand*
JOSEPH HALTON, M.D...C-53.....*Sarasota*
WALLACE H. MITCHELL, M.D...D-54.....*Key West*
JOSEPH J. LOWENTHAL, M.D...B-55.....*Jacksonville*

MEDICAL POSTGRADUATE COURSE

TURNER Z. CASON, M.D., Chm...B-55.....*Jacksonville*
ARTHUR J. BUTT, M.D...AL-53.....*Pensacola*
FRANZ H. STEWART, M.D...D-53.....*Miami*
J. BROWN FARRIOR, M.D...C-54.....*Tampa*
FRANCIS T. HOLLAND, M.D...A-56.....*Tallahassee*

CANCER CONTROL

FRAZIER J. PAYTON, M.D., Chm...D-54.....*Miami*
MILTON C. MALONEY, M.D...AL-53.....*Jacksonville*
ROBERT L. TOLLE, M.D...B-53.....*Orlando*
GEORGE W. MORSE, M.D...A-55.....*Pensacola*
WESLEY W. WILSON, M.D...C-56.....*Tampa*

MEDICAL ECONOMICS

REUBEN B. CHRISMAN, JR., M.D., Chm...AL-53....*Miami*
JOHN E. MAINES, JR., M.D...B-53.....*Gainesville*
HARRISON A. WALKER, M.D...D-54.....*Miami*
WILLIAM H. WALTERS, JR., M.D...C-55.....*Lacoochee*
WILLIAM C. ROBERTS, M.D...A-56.....*Panama City*

VENEREAL DISEASE CONTROL

MELVIN M. SIMMONS, M.D., Chm...C-55.....*Sarasota*
JOHN R. BROWNING, M.D...AL-53.....*Jacksonville*
JOHN C. MCSWEEN, JR., M.D...A-53.....*Pensacola*
WILEY M. SAMS, M.D...D-54.....*Miami*
DAVID W. GODDARD, M.D...B-56.....*Daytona Beach*

TUBERCULOSIS AND PUBLIC HEALTH*

RALPH S. SAPPENFIELD, M.D., Chm...AL-53.....*Miami*
PHILLIP W. HORN, M.D...B-53.....*Jacksonville*
ERASMUS B. HARDEE, M.D...D-54.....*Vero Beach*
LOUIS J. GARCIA, M.D...C-55.....*Tampa*
HARRY S. HOWELL, M.D...A-56.....*Lake City*

*SPECIAL ASSIGNMENT

1. Diabetes Control

STATE CONTROLLED MEDICAL INSTITUTIONS

William D. Rogers, M.D., Chm...A-56....*Chattahoochee*
James L. Anderson, M.D...AL-53.....*Miami*
Bailey B. Sory, Jr., M.D...D-53.....*Palm Beach*
James G. Lyerly, M.D...B-54.....*Jacksonville*
Samuel G. Hibbs, M.D...C-55.....*Tampa*

MATERNAL WELFARE

E. Frank McCall, M.D., Chm...B-56.....*Jacksonville*
T. Bert Fletcher, Jr., M.D...AL-53.....*Tallahassee*
Lowrie W. Blake, M.D...C-53.....*Bradenton*
John N. Sims, Sr., M.D...A-54.....*Live Oak*
Ralph W. Jack, M.D...D-55.....*Miami*

CHILD HEALTH

Luther W. Holloway, M.D., Chm...B-53....*Jacksonville*
James R. Boulware, Jr., M.D...AL-53.....*Lakeland*
Warren W. Quillian, M.D...D-54.....*Coral Gables*
Daniel F. H. Murphey, M.D...C-55.....*St. Petersburg*
Courtland D. Whitaker, M.D...A-56.....*Marianna*

CONSERVATION OF VISION

Ralph N. Greene, Jr., M.D., Chm...AL-53..*Jacksonville*
William Y. Sayad, M.D...D-53.....*West Palm Beach*
Sherman B. Forbes, M.D...C-54.....*Tampa*
G. Tayloe Gwathmey, M.D...B-55.....*Orlando*
Mozart A. Lischkoff, M.D...A-56.....*Pensacola*

ADVISORY TO WOMAN'S AUXILIARY

C. Robert DeArmas, M.D., Chm...B-55....*Daytona Beach*
Benjamin H. Sullivan, M.D...AL-53.....*St. Petersburg*
Edward F. Shaver, M.D...C-53.....*Tampa*
James L. Anderson, M.D...D-54.....*Miami*
Taylor W. Griffin, M.D...A-56.....*Quincy*

REPRESENTATIVES TO INDUSTRIAL COUNCIL*

Charles R. Burbacher, M.D., Chm...D-55..*Coral Gables*
Fred H. Albee, Jr., M.D...AL-53.....*Orlando*
G. Frederick Oetjen, M.D...B-53.....*Jacksonville*
Chas. L. Farrington, M.D...C-54.....*St. Petersburg*
Lee Sharp, M.D...A-56.....*Pensacola*

*SPECIAL ASSIGNMENT

1. *Industrial Health*

COUNCILOR DISTRICTS AND COUNCIL

Eugene G. Peek, Jr., M.D., Chm...AL-53.....*Ocala*
First—Francis M. Watson, M.D...1-54.....*Marianna*
Second—Benjamin A. Wilkinson, M.D...2-53.*Tallahassee*
Third—William C. Thomas, Jr., M.D...3-54..*Gainesville*
Fourth—Eugene L. Jewett, M.D...4-53.....*Orlando*
Fifth—Hugh G. Reaves, M.D...5-53.....*Sarasota*
Sixth—Emmett E. Martin, M.D...6-54.....*Haines City*
Seventh—Erasmus B. Hardee, M.D...7-54....*Vero Beach*
Eighth—Donald W. Smith, M.D...8-53.....*Miami*

GRIEVANCE COMMITTEE

Walter C. Payne, M.D., Chm.....*Pensacola*
David R. Murphey, Jr., M.D.....*Tampa*
Herbert E. White, M.D.....*St. Augustine*
Joseph S. Stewart, M.D.....*Miami*
William C. Thomas, Sr., M.D.....*Gainesville*

ADVISORY TO SELECTIVE SERVICE FOR PHYSICIANS AND ALLIED SPECIALISTS

J. Rocher Chappell, M.D., Chm.....*Orlando*
Thomas H. Bates, M.D...“A”.....*Lake City*
Frank L. Fort, M.D...“B”.....*Jacksonville*
Alvin L. Mills, M.D...“C”.....*St. Petersburg*
John D. Milton, M.D...“D”.....*Miami*

EMERGENCY MEDICAL SERVICE

James V. Freeman, M.D., Chm.....*Jacksonville*
Merritt R. Clements, M.D...“A”.....*Tallahassee*
Vernon A. Lockwood, M.D...“B”.....*St. Augustine*
Herschel G. Cole, M.D...“C”.....*Tampa*
Frederick K. Herpel, M.D...“D”.....*West Palm Beach*

A.M.A. HOUSE OF DELEGATES

Homer L. Pearson, Jr., M.D., Delegate.....*Miami*
Frank D. Gray, M.D., Alternate.....*Orlando*
(Terms expire Dec. 31, 1952)

Louis M. Orr, II, M.D., Delegate.....*Orlando*
Joshua C. Dickinson, M.D., Alternate.....*Tampa*
(Terms expire Dec. 31, 1953)

Herbert L. Bryans, M.D., Delegate.....*Pensacola*
Thomas H. Bates, M. D., Alternate.....*Lake City*
(Terms expire Dec. 31, 1954)

BOARD OF PAST PRESIDENTS

William E. Ross, M.D., 1919.....*Jacksonville*
H. Marshall Taylor, M.D., 1923.....*Jacksonville*
John C. Vinson, M.D., 1924.....*Fort Myers*
John S. McEwan, M.D., 1925.....*Orlando*
H. Mason Smith, M.D., 1926.....*Tampa*
John A. Simmons, M.D., 1927.....*Arcadia*
Frederick J. Waas, M.D., 1928.....*Jacksonville*
Julius C. Davis, M.D., 1930.....*Quincy*
William M. Rowlett, M.D., Chm., 1933.....*Tampa*
Homer L. Pearson, Jr., M.D., 1934.....*Miami*
Herbert L. Bryans, M.D., 1935.....*Pensacola*
Orion O. Feaster, M.D., 1936.....*Renton, Wash.*
Edward Jelks, M.D., 1937.....*Jacksonville*
W. Henry Spiers, M.D., 1938.....*Orlando*
Leigh F. Robinson, M.D., 1939.....*Fort Landerdale*
Walter C. Jones, M.D., 1941.....*Miami*
Eugene G. Peek, Sr., M.D., 1943.....*Ocala*
John R. Boling, M.D., 1944, 1945.....*Tampa*
Shaler Richardson, M.D., 1946.....*Jacksonville*
William C. Thomas, Sr., M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne, M.D., 1949.....*Pensacola*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey, Jr., M.D., Sec'y., 1951.....*Tampa*

From Our President

Citizens First

From his hospital bed a feverish patient surprised his physician by announcing, "I may be a preacher, but I'm a man first, and I can lick you or any of your kin." So with every member of the medical profession; he may be a doctor, but he is a citizen first. In most instances he became a citizen of the United States long before he received the degree of Doctor of Medicine. After he retires from practice, he will still be a citizen. His responsibility to his country preceded his professional obligations and will continue after they cease. As absorbing and demanding as the career of medicine is, it should not preclude the duties of citizenship.

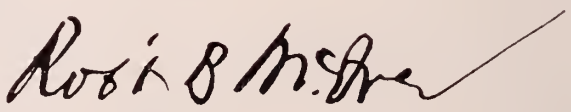
An inherent part of good citizenship is an active, intelligent interest in government. Obviously, the first political obligation of every citizen is to vote. The franchise is the heritage of freedom and is basic to the structure and function of constitutional government. But it must be exercised if freedom is to endure.

Unfortunately, that which is inherited instead of earned is too frequently unappreciated, neglected, treated with indifference, or even abused, squandered and eventually lost. For practical reasons the physician is exempted from jury duty, but no one, not even he, is exempted except in extreme circumstances from the obligation to exercise the franchise.

The physician who fails to engage actively in the affairs of his medical society or to attend hospital staff meetings is in no position to criticize either the medical society or the hospital. Indeed, by failing to make his voice heard he shares the blame for that which is awry. Likewise, the physician who fails to vote is not in good position to complain about taxes, corruption or governmental policies which he finds objectionable. By his surrender of one of the vital duties of citizenship, he assumes a share of the blame for evils at the community, state and national levels.

This election year may well be a significant landmark in American history. Both a privilege and a duty in a nation of free men, the right to vote was never more important than it is now. The fundamental issues of 1952 transcend the usual party politics and affect the future of every American. They call for a clearcut decision by the entire voting population. Let the doctor be sure that he plays his rightful part in that historic decision. It was Edmund Burke who said: "All that is necessary for evil to triumph in the world is for enough good men to do nothing."

To receive the heritage of freedom — first qualify as a legal inheritor. To be a good doctor — first be a good citizen.



The Journal of the
Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. BOX 1018 JACKSONVILLE, FLORIDA

Editor
Shaler Richardson, M.D.

Assistant Editars
Webster Merritt, M.D.
Franz H. Stewart, M.D.

Assaciate Editars

Lavis M. Orr, II, M.D. ..... Orlanda
Jaseph J. Lawenthal, M.D. ..... Jacksanville
Jere W. Annis, M.D. ..... Lakeland
Herschel G. Cale, M.D. ..... Tampa
Wilsan T. Sowder, M.D. ..... Jacksonville
Carlas P. Lamar, M.D. ..... Miami
Walter C. Payne, M.D. ..... Pensacala

Managing Editar
Stewart G. Thompson, D.P.H.
Ernest R. Gibson, Asst.

Committee an Publicatian

Shaler Richardsan, M.D., Chairman ..... Jacksanville
Chas. J. Callins, M.D. ..... Orlanda
James N. Pattersan, M.D. ..... Tampa

Abstract Department

Kenneth A. Marris, M.D., Chairman ..... Jacksanville
Walter C. Janes, M.D. ..... Miami

Quo Vadis

The stench of stale tobacco smoke has almost dissipated, the raucous shoutings have settled to a dim reverberation, and another farcical travesty on American democracy has come to an end. Both political parties have nominated their candidates, and the name-calling, claims and counterclaims will now increase in crescendo until election day.

Looking back through history, one finds that few have been the men who actually have changed the world. Certainly, there have been leaders in the past who have been blamed for catastrophic events and others for ushering in new eras of enlightenment. But always, the time was ripe and the people were willing to follow, whether it was Genghis Khan in his attempt to conquer the world or George Washington in his attempt to form a free country. Without the people, these leaders would have been as prophets crying out in the wilderness or crack-pots preaching in Hyde Park on a soap box.

It has been the custom for generations for each political party not in power to bewail the fact that if the regime in control is allowed to continue, the country is bound for bankruptcy or disintegration. It is like a grandfather looking at his progeny mournfully shaking his head, bemoaning the fact that the younger generation is going to pot and will never amount to much. Thus it has been, and thus we hope it will continue to be, but—.

Recent reports from Germany show that denazification programs on the whole have been futile. It is a known psychologic fact that stereotypes formed in childhood persist throughout life, even if their shadings vary a bit. The generation that grew to manhood during Hitler's reign still accepts his teaching as true. It was taught those children by their parents and accentuated in their schools. The roots are deep.

For the past 20 years one political party has been in complete control of our government. This in itself would not be frightening were it not for the fact that for over 12 years a strong personality was at the helm, a man with a purpose, a man on a white horse who in times of despair offered a change — a new deal — in a magnetic, cultured, and compelling voice. The ground was fertile; his seed took root and was fruitful.

To remain static and dormant is to decay. Progress by definition is dynamic. Thomas Jefferson, whom no one would call a communist, believed that changes in government were healthful even if the changes necessitated a small revolution. Certainly in 1932 we all welcomed a change. But with our now gained hindsight, would we again welcome a change from our depression-riddled economy if we knew at the time where this change was to lead us? The "forgotten man" sat on a king's throne. Labor became the power with whom to reckon. Capital was given a nasty connotation. The "pump had to be primed" with staggering government spendings. People joked about the sewers for nowhere the WPA was building, little realizing that it was, after all, their

money that was being poured down those sewers.

What had happened to America? We had had changes in political parties before and hope we may have them again. With the change we obtained in 1932 came a group of high-minded socially conscious gentlemen. They had a purpose. For them to give the citizen a vote and voice in his government was not enough. They, who were the government, must protect this citizen — nurture him from a child with the aid of government monies and help bury him at death with federal funds. If he were unemployed, government monies would pay him. A neat change took place. It is now apparent that the people have stopped running the government — the government is now running them. With the help of wartime emergency powers which continue to exist, the federal government was able to encroach more and more on the inalienable rights of individuals as set forth in democracy's last fort — our Constitution. Always, we were told, it was for the country's good — the individual must yield for the commonweal, — private enterprise was impotent and hence the government must take over this function and that. Indeed private enterprise is becoming impotent solely because government regulations and taxations make any venture for gain or expansion practically impossible. The fetters on industry are so great that only the federal government can engage in new ventures. The incentive of profit is gone. The great blessing of collective bargaining bestowed on the American worker has made him mute before his labor bosses. Yes, this group of high-minded socially conscious political dreamers who took over in 1932 have pretty well proved to us we may never have another depression — neither will we ever have free competitive expansion. We are entering a great new era of mediocrity.

Any bureaucracy seeks to perpetuate itself. Our federal government during the past 20 years has developed more bureaus than all other administrations, the explanation being that more is being done for the people. Evidently what is being done to the people does not matter. Once a bureaucracy reaches a certain size in a democracy, it is impossible to get rid of it because bureaucrats and their relatives control enough votes, and do vote, to win any election.

In the coming election there are numerous issues at variance in the two parties, but basically only two are of importance. Firstly, do we wish to perpetuate further the present bureaucracy and dynasty filled as it is with graft, dishonesty, and lack of true leadership? Secondly, do we wish to continue the paternalistic government set up in 1932, which can and will eventually lead to a new type of American government which may be democratic in name but certainly socialistic in action? Do we wish to relinquish our right to free endeavor, involving as it does the prospect of lean years as well as prosperous ones, for a lifetime of mediocre living?

Basically, the Democratic Party's campaign will be built around the philosophy that capital, labor and the farmer "never had it so good." If they are giving us socialism, then it is socialism we need and want. Certainly on the surface this is an excellent argument — one which won Harry S. Truman the presidency in 1948 — but an argument which is not true according to the Democrats' own Department of Labor statistics. These show that dollar for dollar, the average worker has less dollar buying ability than in 1939.

The Republican Party offers us a promise of reform — a crusade to sweep out from office those who by their lust for power, greed and corruption crave more and more authority to secure their bureaucracy more firmly. It offers also a hope to engage in free endeavor without the threat of the government taxing the incentive out of industry or crucifying a profession on the altar of a welfare state.

The very fact that we still have elections shows that American Democracy is not dead. It will only die if you fail to vote. It is not believed that either candidate of the two major political parties is of such strength and calibre that he alone will change the course of our history. The continuation of our present policies, however, will eventually lead to a point of no return. The seeds sown and cultivated for 20 years have taken root. Some may never be uprooted. Maybe none should. The choice is yours, to continue onward or change course. Quo Vadis?

Civil Defense Medical Supplies

Of all federal money spent on civil defense, approximately 70 per cent is going for medical purposes, chiefly matching grants to states for local medical stockpiling and all-federal regional stockpiles.[1] The annual report of Administrator Millard Caldwell of the Federal Civil Defense Administration, covering the first full year's operations, reveals that half of some $100,000,000 ap-

propriated for all purposes has been earmarked for all-federal medical purposes. Twenty million will be expended either for federal medical purchases or matching grants to states.

The report estimated that by June 1952 about $90,000,000 in medical supplies would be procured or would be on order. The extra $20,000,000 was to come from nonfederal sources.

During 1951, regional, state and local civil defense directors received specifications for about 200 individual medical items, which they were privileged to order independently or through the Federal Civil Defense Administration. It was expected that within the present year 58 regional warehouses would become available for stockpiling of federal supplies, both medical and engineering.

State and local officials are being encouraged to employ the "unitizing" system used in the federal warehouses. To be immediately available at the time of emergency, supplies are warehoused by the "unitizing" technic. Instead of all items of a given type, such as surgical instruments, being stored in one area, items forming a unit are stored together. At the time the report was issued, plans called for storage of medical supplies and equipment in units necessary for a 200 bed emergency hospital. States were being urged to store their own supplies in units sufficient to care for 1,000 casualties. In an emergency, a local community would have to depend on its own medical supplies pending arrival of medical units from the nearest federal regional warehouse.

It is planned that on the federal level there will be exchange of perishable medical supplies with other government agencies. States expect to rotate their own perishable items with state hospitals and other institutions.

For the fiscal year 1953, the program calls for appropriations from the Congress amounting to $193,000,000 for federal medical stockpiling.[2] No matching funds for local stockpiling are requested for next year.

1. 70% of Federal Civil Defense Funds Go for Medical Purposes, Capitol Clinic 3:2 (April 29) 1952.
2. Federal, State Medical Stockpiles May Exceed $80 Million by Mid-Year, Capitol Clinic 3:3 (April 1) 1952.

Quiet for Heart Patient

Make haste slowly in moving a patient immediately after a heart attack. Dr. Elmer Milch and his associates of Buffalo, N. Y., gave this advice at the recent meeting of the American Medical Association. It was prompted by investigations which led them to conclude that perhaps two thirds of the sudden deaths from cardiac disease which occur in young men are preventable if the patient is not moved during the crucial hours right after the attack and is kept very quiet.

They advise keeping the patient resting quietly at home, on in his office if he suffers the attack there, for the first four hours, using morphine or other sedatives to keep him quiet and giving oxygen if necessary. They stress not moving him too soon, for such a patient, when rushed to the hospital, is too often dead on arrival or dies shortly thereafter.

In their animal experimentation these investigators observed that in dogs which were anesthetized and prepared for study of the effects of blocking of the coronary arteries, the condition often terminating fatally in young men, fibrillation and death followed the slightest outside stimulus, such as brushing against the operating table. In their efforts to reduce these effects of outside stimuli, they prevented the stimuli from reaching the heart by cutting the sympathetic nerves in the chest and thereby reduced the death rate from 42 to 14 per cent. They considered this accomplishment good evidence of the importance of keeping the patient absolutely quiet during the crucial period of several hours immediately following the attack.

Reports on Poisoning Sought

A nationwide toxicologic study of cases of poisoning resulting from the use of insecticides, rodenticides, fungicides, weed killers, fumigants, repellents and related types of chemicals used in agriculture and the home currently is being undertaken by the Committee on Pesticides of the Council on Pharmacy and Chemistry of the American Medical Association. The information obtained will be used to expand the committee's permanent file of such cases for use by physicians and allied medical personnel.

The committee is appealing to physicians to submit records on cases of nonfatal and fatal poisonings from pesticides. It is functioning as a center for reporting poisoning cases of this type, and unpublished isolated cases coming to its attention have supplied much of the information it has compiled. In most instances, summary data on the pertinent facts of the poisoning and the circumstances of their occurrence furnish sufficient information.

This appeal should evoke wide interest. Doubtless Florida physicians, particularly in the citrus areas, will have cases to contribute to the committee's file.

ILO — Danger Ahead!

To American physicians today, the three initials "ILO" spell danger ahead. Or at least they should, for they stand for an international body which eventually may change the whole concept of medical practice throughout the world.

Surprising as it may seem, socialized medicine the international way is now the favored approach. The time has come when under United Nations plans an attempt is being made through treaty-making powers to dictate the relationship between American citizens and their government. It is an astounding fact that this great nation, vaunted as leader of the free world, is now under greater threat of socialism by treaty than by domestic legislation. The immediate source of that danger is the ILO.

The International Labor Organization is an affiliated agency of the United Nations comprising some 60 active member-governments. It is one of the oldest and most important of the maze of international organizations functioning today. Its policy-making body is the International Labor Conference, which meets annually, usually in Geneva, Switzerland, where the staff maintains permanent headquarters.

At its annual meeting last June, this conference exercised its authority of formulating international treaties in its adoption of the so-called "Social Security Minimum Standards Convention of 1952." This convention (treaty) recommends that member nations put into effect minimum standards of social security in nine fields — medical care, sickness benefits, unemployment benefits, old age pensions, employment injury benefits, family allowances, maternity benefits, invalid benefits, and survivors' benefits. Carefully distributed throughout the covenant, the medical benefits plainly constitute socialized medicine when considered together.

The medical care section, for example, stipulates in part that a country ratifying must provide a system of compulsory health insurance, or (1) private, voluntary health insurance administered by public authorities under established regulations set by law, or (2) private, voluntary health insurance administered by insurance companies under government supervision.

Now that the domestic battle against political medicine has been won, at least for the time being, in state legislatures and the Congress, the new international approach threatens loss of the war against this evil, largely because of lack of recognition of the possibility of political and economic regimentation from external sources. With the public unaware of the dangers inherent in the treaty-making power, the nation's international representatives have jeopardized national sovereignty and the Constitution as well as American medicine by "wholesale approval of treaties, conventions, and executive agreements."

Ratification of this newest ILO convention requires only a two-third vote of the Senate. Such a vote would establish socialized medicine in this country regardless of the wishes of the majority of the members of the Congress and the public to the contrary. That it could slip in through the backdoor under the guise of an international treaty seems all but inconceivable, but this subtle approach to realization of the socialist's dream of cradle-to-the-grave security is the reason why ILO spells danger.

The time is surely ripe for physicians to acquaint themselves fully with this latest development and to realize that only the opening skirmish in the socialized medicine battle may be behind them. The American Medical Association has for years kept watch of the ILO and lately has published a number of articles on this organization and its health objectives. This material[1] is regarded as "must" reading for every physician. Do not miss it, Doctor.

1. For back reading, physicians are invited to turn to the Journal of the American Medical Association: Organization Section, May 31, 1952; page 869 of the June 28 issue, containing the excellent statement of A.M.A. President Louis H. Bauer; the Washington News Section of the issue of July 12, 1952; the editorial on page 1572 and the Organization Section of the issue of Aug. 23, 1952; and Capitol Clinic Vol. 3, No. 26, July 1, 1952.

Southeastern States Cancer Seminar Tampa, Oct. 30 - Nov. 1

The Southeastern States Cancer Seminar will be held this year at the Tampa Terrace Hotel in Tampa. The dates for this sixth annual meeting are October 30 and 31 and November 1. The attendance during the last five years has been excellent, and it is anticipated that physicians throughout the Southeastern states will welcome the exceptional opportunity again this year and attend in large numbers.

The American Cancer Society, Florida Division, and the Florida State Board of Health, with the cooperation of the Florida Medical Association, sponsor this annual Seminar.

The lecturers and the specialty they represent are: Chemotherapy, Dr. C. P. Rhoads, Memorial Center, New York City; Hematology, Dr. Leon

Jacobson, University of Chicago Clinic, Chicago; Gynecology, Dr. John L. McKelvey, Head of Obstetrics and Gynecology, University of Minnesota Medical School, Minneapolis; Lip, Mouth, Throat, Dr. John J. Conley, Pack Medical Group, New York City; Pathology, Dr. Hugh G. Grady, Director, American Registry of Pathology, Armed Forces Institute of Pathology, Washington, D. C.; Pathology, Dr. Elson B. Helwig, Armed Forces Institute of Pathology, Washington, D. C.; Radiology, Dr. Charles L. Martin, Dallas; Radiology, Dr. W. Edward Chamberlain, Philadelphia; Skin, Dr. Joseph A. Elliott, Jr., Charlotte, N. C.; and Surgery, Dr. Clarence Gardner, Duke University Hospital, Durham, N. C.

Postgraduate Assembly in Endocrinology Miami Beach, November 3-8

The fifth annual Postgraduate Assembly in Endocrinology and Metabolism will take place on Nov. 3-8, 1952 at the Roney-Plaza Hotel in Miami Beach. This assembly is sponsored by the Endocrine Society, formerly the Association for the Study of Internal Secretions, and is being held in Miami Beach for the second time in two and one-half years. Registration is limited to 200 and closes October 1. The fee is $75.

An intensive and practical review of the newer developments in endocrinology and metabolism will be presented, with emphasis on the relation of these subjects to general medicine. The program has been accepted for credit by The American Academy of General Practice.

A faculty of 20 eminently qualified clinicians and investigators will present 64 scientific lectures covering all phases of endocrinology and metabolic disorders. There will be case presentations of various types of endocrine and related problems and also question and answer periods. Laboratory procedures of aid in endocrine diagnosis will be demonstrated by trained technicians. In addition, scientific exhibits will be presented by members of the faculty, and a bound copy of the proceedings will be available to registrants.

This is one of the most important postgraduate seminars held in this country and is the first, at least in this area, in which simultaneous translations into Spanish of all presentations will be provided through earphones. Wide publicity has been given this seminar in the medical press of Latin American countries, and several governments have already announced their intention of sending official medical representatives. Those in attendance from these countries have been extended an invitation to attend the annual meeting of the Southern Medical Association, which will be held in Miami the following week, November 10-13.

Dr. Carlos P. Lamar, Director of the Department of Endocrinology and Metabolism of the Jackson Memorial Hospital in Miami, is a member of the distinguished faculty and is also chairman of the local committee arranging for the meeting. Dr. Henry H. Turner, Secretary-Treasurer, The Endocrine Society, 1200 N. Walker, Oklahoma City 3, Okla., is receiving applications.

Southern Medical Association Meeting Miami, November 10-13

The forty-sixth annual meeting of the Southern Medical Association will convene in Miami on Monday, Nov. 10, 1952 and will continue through Thursday, November 13. The Dade County Medical Association will serve as host to this body for the fourth time and is making elaborate plans for welcoming the physicians of the South to Florida's popular convention city.

In contrast to arrangements for the last meeting held in Miami, all activities will be centered in the downtown bayfront area, in hotels on Biscayne Boulevard and in the Library and Municipal Auditorium in Bayfront Park, thereby eliminating the transportation problem.

An excellent program has been arranged by the officers of the twenty-one sections. There are Sections on General Practice, Medicine, Gastroenterology, Neurology and Psychiatry, Pediatrics, Pathology, Radiology, Dermatology and Syphilology, Allergy, Physical Medicine and Rehabilitation, Industrial Medicine and Surgery, Surgery, Orthopedic and Traumatic Surgery, Gynecology, Obstetrics, Urology, Proctology, Ophthalmology and Otolaryngology, Anesthesiology, Public Health, and Medical Education and Hospital Training. The diversity of subjects to be presented and the distinguished essayists insure broad coverage of all aspects of medical progress.

President R. J. Wilkinson of Huntington, W. Va., who was unable to attend the Dallas meeting last year because of illness, is actively engaged in meeting the customary demands of his high office in preparation for this meeting. He will be succeeded in office at the close of the meeting by Dr. Walter C. Jones of Miami, a past president of the Florida Medical Association.

Medical District Meetings October 27-31, 1952

Dr. Eugene G. Peek, Jr., of Ocala, Chairman of Council, has announced that the programs for the four annual Medical District Meetings have been completed. These programs, scheduled for October 27, 29, 30 and 31, have been arranged by Dr. Peek with the assistance of the eight councilors. Cooperating in the many details of the meetings are the secretaries of the host county medical societies: Bay, Dr. William F. Humphreys, Jr., of Panama City; Pinellas, Dr. Whitman C. McConnell of St. Petersburg; St. Lucie-Okeechobee-Martin, Dr. Adrian M. Sample of Fort Pierce; and Volusia, Dr. Robert L. Miller of Daytona Beach.

Medical District Meetings are designed to enable Association officers and members to meet together with a minimum of traveling for those attending, and so that busy doctors will be away from their practices as short a time as possible. The scientific program of each meeting has been planned to be sufficiently diversified to be of value to general and specializing practitioner alike.

Following the scientific program, officers of the Association will present pertinent and interesting information at each of the meetings. Association officers who will speak include Drs. Robert B. McIver, president; Frederick K. Herpel, president-elect; Samuel M. Day, secretary-treasurer; and Shaler Richardson, editor of The Journal. Dr. J. Rocher Chappell, chairman of the Committee on Advisory to Selective Service for Physicians and Allied Specialists, will join with the officers in bringing timely information to the members. These general sessions will be in charge of Dr. Peek, assisted by a councilor from each district as follows: Panama City, Dr. Benjamin A. Wilkinson of Tallahassee; St. Petersburg, Dr. Hugh G. Reaves of Sarasota; Fort Pierce, Dr. Donald W. Smith of Miami; and Daytona Beach, Dr. Eugene L. Jewett of Orlando.

All sessions begin at 2:30 p.m. on the days indicated on the program below. At 5:45 refreshments will be served by the host societies. Dinner will follow at 6:30. Printed programs will be mailed to all members of the Association prior to the meetings.

Dr. H. Phillip Hampton, Chairman of the Committee on Legislation and Public Policy, will preside at the evening session, beginning at 7:30. Legislation on state and national levels of interest to the medical profession will be the subject for discussion. Association members and members of the Woman's Auxiliary are urged to attend.

Scientific Assemblies — Four Medical Districts

All Meetings — 2:30 p.m.

Monday, October 27, 1952

Panama City — A

St. Andrews Bay Yacht Club

Presiding: Eugene G. Peek, Jr., Chairman of Council, and Francis M. Watson of Marianna, Councilor of District 1.

Address of Welcome, Charles H. Daffin of Panama City, President, Bay County Medical Society.

"A Phase of Postpartum Bleeding with Case Reports," Merritt R. Clements, Tallahassee.

"Thoracic Problems of Interest to the General Practitioner," (by invitation), Hawley H. Seiler, Tampa.

Wednesday, October 29, 1952

St. Petersburg — C

Detroit Hotel

Presiding: Eugene G. Peek, Jr., and Emmett E. Martin of Haines City, Councilor of District 6.

Address of Welcome, John P. Rowell of St. Petersburg, President, Pinellas County Medical Society.

"Management of Thoracic Problems in General Practice," Leffie M. Carlton, Jr., Tampa.

"The Female Urethra in the Diagnosis of Abdominal and Pelvic Pain," Melvin M. Simmons, Sarasota.

Thursday, October 30, 1952

Fort Pierce — D

Flamingo Restaurant

Presiding: Eugene G. Peek, Jr., and Erasmus B. Hardee of Vero Beach, Councilor of District 7.

Address of Welcome, Richard F. Sinnott of Fort Pierce, President of St. Lucie-Okeechobee-Martin County Medical Society.

"Diabetic Neuropathy," Sidney Davidson, Lake Worth.

"The Early Diagnosis and Management of the Common Neoplasms," Richard M. Fleming, Miami.

Friday, October 31, 1952

Daytona Beach — B

Daytona Beach Gun Club

Presiding: Eugene G. Peek, Jr., and William C. Thomas, Jr., of Gainesville, Councilor of District 3.

Address of Welcome, J. Richard West of Daytona Beach, President, Volusia County Medical Society.

"Problems in Sterility," Edward P. Madden, Daytona Beach.

"Management of the Ambulatory Cardiac," Norman E. Williams, Daytona Beach.

Dr. Bauer, A.M.A. President, Addresses Florida Medical Committee For Better Government

An address by Dr. Louis H. Bauer, President of the American Medical Association, highlighted the final session of the third annual meeting of the Florida Medical Committee for Better Government. Following a luncheon in the George Washington Hotel Auditorium at 12:30 p.m. on Sept. 7, 1952, Dr. Bauer spoke on "Problems of Medicine, National and International" before approximately 500 Florida doctors and their wives. He was introduced by Dr. Robert B. McIver of Jacksonville, President of the Florida Medical Association.

Dr. Bauer opened his address by saying, "The American Medical Association having thrown itself into the struggle to protect the freedom of medicine, much of its publicity has been devoted to the matter of socialized medicine. Now, however, that we have won a breathing space in our struggle, we are endeavoring to bring to the attention of the public and the profession the other matters with which we are concerned and which, as a matter of fact, have always occupied the major portion of our efforts. The entire environment of medical practice today is due to these activities of the American Medical Association. The very fact that every medical school in the United States is an acceptable school is the direct result of the Association's campaign initiated shortly after the turn of the century to raise the standards of medical education in this country. As a result, not only do we have nothing but high grade medical schools, but the level of medical education here is unsurpassed anywhere in the world.

"The work of the councils and bureaus of the American Medical Association," continued Dr. Bauer, "has set standards in hospitals and in medical care which likewise are unsurpassed. The profession and the public have been protected against undesirable secrecy in objectionable advertising of proprietary medicines. Standards have been set for therapeutic agents, special purpose foods, devices and methods employed in the practice of medicine. Quackery, nostrums and charlatanism have been shown up and in many cases eliminated. The Association has done much and is expanding its program to educate the public in matters of health through radio and television projects, its program on school health and its consultation service to governmental and lay organizations. Its publications are outstanding and cover the field of medicine. The Journal of the American Medical Association is recognized as the greatest medical publication in the world."

After enumerating the many services rendered by the various councils and bureaus, Dr. Bauer commented, "I find in going about the country that many members of the Association and many members of the general public are totally unaware of these activities, or if they are aware of them, they take them for granted.

"History has shown that whenever groups within the medical profession start to bargain independently, the influence of the profession is lost. That has been the case in Great Britain. If one had been asked 25 years ago what medicine of the future would be like, I doubt if anyone could have come up with a very revealing answer. I am

not sure that anyone can do so in any very certain fashion for the next 25 years. Certain patterns, however, have developed which at least indicate definite trends. Some of these trends are heartening, particularly those in medical science. Other trends, particularly those in the socioeconomic field, are not only disheartening but are rather alarming. If some of these latter trends are allowed to continue unchecked, the very science of medicine will suffer."

Observing that there is no reason to believe any disease exists for which a cure and prevention will not be found eventually, Dr. Bauer continued, "All this leads to longer life. The average life span has increased 20 years in the last 50 years and will probably continue to increase. This brings up economic problems. At the present time, the increased life span has resulted in millions living to an age where they are subject to the degenerative diseases accompanying old age. This interposes an immediate problem, the care and treatment of chronic and degenerative diseases.

"In the last quarter century the status of the physician is altered in his relations to society and government, greatly in some areas, and to a certain extent in all areas. Government has come to play an increasing part in medicine. To some degree this was essential. Many phases of public health cannot be adequately controlled without the participation of government. For example, environmental sanitation, protection of food, milk and water supplies, and control of insect-borne diseases must be a function of government health departments, but such matters must be carried out on a community basis and require a police power."

This distinguished servant of medicine was firm in his conviction that the medical profession should lead in any health program. Commenting on health plans, he said, "The prepayment system of medical care is here to stay. The question to be decided is whether the system should be voluntary or compulsory. In many areas of the world, it is compulsory. In this country, so far, we have kept it on a voluntary basis. Whether or not we continue to do so depends largely on the medical profession. Many seem to think that we have won our fight against socialized medicine. I assure you we have not and we cannot relax. We have won a breathing space. The socializers are not for the moment trying to move in a program of socialized medicine through the front door, but they are still trying to get it in by degrees through the back door. They have not given up, nor will they give up until the American people show that they will have no more of socialism whether it is in the form of admitted socialism or in the form of pink sugar-coated socialistic medical pills.

"I have had the opportunity during the last five years to visit Europe ten times. In not one single country have the plans involving greater participation of government resulted in a betterment of medical care, and in many they have resulted in a poorer type of medical care. The medical profession is usually at odds with the government. The government ignores the medical profession, and professional matters are decided by laymen. There seems no doubt that wherever government has established a strangle hold on medical care, it is the eventual aim of government to make doctors full time salaried servants of the state. History shows that wherever government gets its foot in the door of medical care, there is more and more governmental control, more and more regimentation, steadily increasing deficits in the insurance plan and deterioration of the standards of medical care. The public is the loser.

"In this country, medical care has become political. The majority of the hopeful proponents of compulsory insurance are either socialistic in their thinking, or are using the proposal as a lure to get votes by offering the public something they cannot possibly deliver. The Health Minister of Australia has stated in substance that it is impossible to make any health plan work which will not enlist the cooperation of those who have to carry it out. In other words, no health plan can be carried out without the help of the medical profession, and, if they disapprove the plan, it cannot be made a success."

Dr. Bauer outlined the steps necessary to prevent socialized medicine in this country. "We must see that the scope of public health units as defined by the American Medical Association is generally accepted, and then coverage within that scope must be extended to the whole country. Diagnostic facilities must be made available to the whole country. Diagnostic facilities must be made available within the reach of any community. Hospital facilities must be adequate, but full use must be made of existing facilities before new ones are built. Local pride or local politics must not be allowed to result in the building of a hospital in an area which does not have one when adequate facilities are available within a few miles and good roads lead to those facilities. Agreements must be made between the medical profession and

local government agencies to insure adequate medical care to the indigent.

"There are now 86 million people in the United States who carry hospital insurance. The medical profession must give 100 per cent cooperation to the voluntary plan. The doctors themselves must clean house. Those physicians who are charging exorbitant fees are constantly getting the medical profession into discredit with the public. Whereas only a small proportion are guilty of so doing, those few do more harm than ten times the number of ethical physicians can make up for because they are the ones who get the publicity.

"Health and medicine require teamwork, but the physician must be captain of the team. The medical profession must stand together as a unit. The confidential relationship between physician and patient must be maintained. If that is lost, medicine will degenerate into an assembly line product. When it is said that government is the only agency with enough money to give financial support to medical schools, my answer is that the government has no money except that which it takes out of your pocket or mine. Our federal government has expanded into such an octopus that it reaches into every corner of our lives. It has been extravagant and wasteful. It has seized nearly all available sources of taxation, leaving little to the state. Should the government gain control of our medical schools by furnishing the greater part of their financial support, do not let anyone persuade you that the government would never interfere with the operation of the schools.

"The Federal Security Agency is the greatest propaganda agency for socialism in the United States today. It has not been content with trying to force a program of socialized medicine on the people of the United States, but has gone at least into one other country and tried to force such a program on the people of that country. Our free institutions and traditions are in grave danger of being lost by the apathy of the American people. In the last presidential election only 51 per cent of those eligible to vote exercised their right of franchise. That means that 26 per cent of the people control the country. Only in a few places in the world does this precious right of franchise remain. Centuries ago Plato said the penalty paid by good men for refusing to take part in government is to live under the government by bad men.

"Our form of government has been steadily changing from a democracy within a republic to a bureaucracy. The people of this country have been encouraged to depend upon government for everything in life. Once personal liberties are lost, they are never regained. We have now reached the stage where nearly 35 per cent of our income goes to national, state and local taxation. This is a dangerous level. Beyond that point, complete socialism becomes inevitable. The most important crusade this or any organization can make is a crusade for good citizenship and acceptance of civic responsibilities. Use your influence to get people to register and vote, regardless of how they vote.

"Finally, we must arouse the American people to a realization that if medical service is to progress, if the standards of medical education and medical care are to be maintained and advanced, then socialization not only of medicine but of anything else in our national economy cannot be tolerated, or we shall lose everything that has made the United States of America the greatest country in the world."

Dr. Bauer's address climaxed a two day gathering of the Florida Medical Committee for Better Government. Senator J. Marshall Butler (R.Md.) spoke to the group at the opening luncheon at the George Washington Hotel at 1 p.m. on Saturday, September 6. At 8:30 that evening Congressman Charles E. Bennett (D.Fla.) was the speaker. The public was invited to hear both political speakers. Their addresses were carried on the radio, as was Dr. Bauer's address.

The agenda for Sunday included a business meeting at 9:30 a.m. Newly elected officers are: Chairman, Dr. Samuel G. Hibbs, Tampa; Vice Chairman, Dr. Francis T. Holland, Tallahassee; Secretary, Dr. Collin F. Baker, Jr., Tampa; Treasurer, Dr. Charles F. Henley, Jacksonville. The District Chairmen are: District 1, Dr. Francis H. Langley, St. Petersburg; District 2, Dr. O. E. Harrell, Jacksonville; District 3, Dr. James T. Cook, Jr., Marianna; District 4, Dr. Richard F. Stover, Miami; District 5, Dr. C. Robert DeArmas, Daytona Beach; District 6, Dr. Alvin E. Murphy, Palm Beach; District 7, Dr. Jere W. Annis, Lakeland; District 8, Dr. J. Maxey Dell, Jr., Gainesville.

At this business session, the Florida Medical Committee for Better Government, which functions apart from any organized county, state or national medical society, went on record as endorsing Gen. Dwight D. Eisenhower for president, Sen. Richard M. Nixon for Vice President, Sen. Spessard Holland for re-election as the senior

senator from Florida and Dan McCarty for governor of Florida. It was emphasized at the time of these endorsements that the Committee as such would not carry on any active campaign, but it recommended to its individual members that they support the candidates as endorsed.

STATE BOARD OF HEALTH

Treatment of Selected Cancer Patients At Oak Ridge Institute of Nuclear Studies

Arrangements have been made whereby selected cancer patients from Florida may be treated at the Oak Ridge Institute of Nuclear Studies at Oak Ridge, Tenn. The State Board of Health Cancer Division Director has been appointed consultant by the Oak Ridge Institute to act as clearing house for those patients from Florida who may be treated at this Institute.

There is no charge for hospitalization at the Institute, regardless of the patient's finances. However, transportation must be paid by the patient or some other source from his home to Oak Ridge and return. A booklet giving information to the patients has been made available to each of the tumor clinics in the state and each patient considered for admission should be familiar with the contents of this booklet. Before any patient is sent to Oak Ridge application has to be made on a special form and approved by the Director of the Cancer Division of the State Board of Health. The hospital at Oak Ridge is a very small hospital and no patient should be referred there without proper credentials. All patients should be processed through one of the fourteen tumor clinics in the state if possible.

The Institute is interested in treating only the following types of patients:

1. Patients with bone metastases, particularly osteogenic in type, who have already had the benefit of standard forms of therapy.
2. Osteogenic sarcoma in any stage of the disease.
3. Carcinoma of the thyroid.
4. Patients with pleural effusions or ascites caused by metastatic neoplasms and who have prominent symptoms related to the presence of the fluid. Patients who are becoming rapidly worse or who have impending intestinal obstruction are not suitable.
5. Patients with plasma cell myeloma. The Institute would especially like to study 1 or 2 patients with plasma cell leukemia.
6. Chronic granulocytic leukemia.
7. Polycythemia vera.
8. Acute leukemia in adults with high peripheral white cell counts.

The hospital is also interested in having:

1. Any histologic sections for their files, on cases referred.
2. A brief clinical summary on all cases.
3. In patients with ascites on pleural effusions they would like to know the amounts of paracenteses.
4. Any x-rays that have been made on the patients will be helpful and these will be photographed and returned if desired.

It is believed that this is a service that will be helpful to the types of cancer cases mentioned above. If there are any questions about this service inquiries may be forwarded to Dr. L. L. Parks, Cancer Division, State Board of Health, Jacksonville.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Richard W. McDowell of Jacksonville announce the birth of a son, Jeffrey Jules, on July 6, 1952.

Dr. and Mrs. John S. Cowdery of Jacksonville announce the birth of a son, Robert Collins, on July 26, 1952.

Dr. and Mrs. Thaddeus M. Moseley, III, of Jacksonville announce the birth of a son, William Armistead, on Aug. 11, 1952.

Dr. and Mrs. Jerome H. Newman of Jacksonville announce the birth of a daughter, Fanny, on Sept. 7, 1952.

Dr. and Mrs. Irvin C. Schneider of Jacksonville announce the birth of a son, Kenneth Evans, on Sept. 7, 1952.

Marriages

Dr. David S. Light of Miami Beach and Miss Letty Pogul of Forest Hills, N. Y., were married on Aug. 30, 1952.

Deaths — Members

Sperry, Herbert G., Coral Gables ..... July 6, 1952
Owens, W. Duncan, Warrington, Va. ..... Aug. 6, 1952
Pay, Wilson C., DeLand ..... Aug. 12, 1952
Harrison, M. M., Bradenton ..... Aug. 16, 1952
Ricker, Samuel F., Orlando ..... Aug. 18, 1952
Weems, William H., West Palm Beach ..... Aug. 30, 1952

Deaths — Other Doctors

Thompson, Hubert O., Tyler, Tex. ..... March 7, 1952
Vogt, Elkin, Lithonia, Ga. ..... May 5, 1952
Pernoud, Flavius G., Jr., St. Louis, Mo. ..... June 9, 1952

STATE NEWS ITEMS

Distribution of the American Medical Association publication, "Your Money's Worth in Health," is being carried out in Sanford by Dr. J. Clifford Boyce in cooperation with a local druggist who has agreed to wrap one of the booklets with each prescription. Dr. Boyce said the plan assures that the publication will go to the person for whom it was originally intended. The druggist says he is going to do more than wrap the booklet with each prescription. He's going to ask the customer to read it.

Dr. Douglas D. Murphy of Venice spoke on "Prolonging Life" at a recent meeting of the local Rotary Club.

Dr. Webster Merritt of Jacksonville was the principal speaker at a dinner held during the refresher course for pharmacists in Jacksonville in June. His subject was "A Down to Earth Talk."

Dr. J. Archer Smith, Jr., of Homestead was honored recently for a quarter-century of service at Dade County Hospital. More than 100 friends witnessed the presentation to Dr. Smith of a scroll signed by all the doctors and personnel of the hospital.

Dr. Sullivan G. Bedell of Jacksonville has been elected vice president of the Board of Directors of the Duval County Child Guidance Clinic. He has served as president for the past year.

Dr. Clarence M. Sharp of Jacksonville has been elected to the Executive Council of the American Trudeau Society.

Dr. Samuel E. Kaplan of Venice has returned to his practice after atending a postgraduate course in August.

Drs. Hugh A. Carithers and Luther W. Holloway of Jacksonville gave lectures at the Southern Pediatric Seminar held in Saluda, N. C., in July.

Dr. Turner Z. Cason of Jacksonville was moderator for a discussion on the need for a program of professional education in heart diseases before a meeting of the Duval County Chapter of the Florida Heart Association in June.

Dr. Wiley T. Simpson of Winter Haven is attending the meeting of the World Medical Association in Athens, Greece, October 12 through 16.

Dr. J. Champneys Taylor of Jacksonville has returned to his practice after attending clinics and conferences at the Mayo Clinic.

Dr. C. Burling Roesch of Jacksonville was the principal speaker at the commencement exercises of the second graduating class to receive practical nursing certificates at the Jacksonville School of Technology.

Dr. W. Tracy Haverfield of Miami spoke on brain surgery at the second session of the Institute on Nursing, sponsored by the University of Miami and the Florida League of Nursing Education, district two, recently. Dr. DeWitt C. Daughtry of Miami spoke on surgery of the heart.

Dr. Percy H. Guinand of Clearwater attended the International Diabetic Congress in Amsterdam, Holland during July.

Dr. Homer L. Pearson, Jr., Miami, was a guest speaker at the joint convention of the New Hampshire Medical Society and the Vermont State Medical Society, at Brettonwood, N. H., on September 9.

Representatives from Florida at the Medical Public Relations Institute at the Edgewater Beach Hotel in Chicago, September 4 and 5, included Ernest Gibson and Tom Jarvis from the Association office and Mrs. Louis Johnson from the Dade County Medical Association.

Sponsored by the Department of Public Relations of the American Medical Association, this working clinic was designed primarily for lay personnel of state and county medical societies.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

FOR SALE: Spencer Microscope; binocular; inclined lens mounting; mechanical stage; practically new; perfect condition; case included. Write: JDM, 1708 Conway, Orlando, Fla.

WANTED: M.D. for general practice in Mulberry, Fla. Address all inquiries to the City Council, Mulberry, Fla.

WANTED: Capable, successful, Michigan G.P. desires opportunity in Palm Beach, Fort Lauderdale or Miami. Forty-two years, married, two children. Florida license. Will invest. Write 69-67, P.O. Box 1018, Jacksonville, Fla.

SURGEON: General and Plastic, seven years straight surgical training, Florida license, Board eligible, veteran, age 35, married, desires association or location in larger city. Write 69-68, P.O. Box 1018, Jacksonville, Fla.

ATTENTION DOCTORS: For rent in Daytona Beach, Florida. Former physician's office. Share waiting room with successful dentist in adjoining office. Attractive one-story professional type building designed and built by a doctor. Exceptionally good down-town location—no other doctor within six blocks. You can't go wrong by casting your future with fast growing Daytona Beach. You'll have a nice place to live and every prospect of building up a successful and lucrative practice. Rent $80 per month. Write owner, P. O. Box 5451 or tel. 8262.

LOCATION DESIRED: M. D. anesthesiologist wishes location for private or joint practice. Willing to do some general practice in addition. Write 69-69, P. O. Box 1018, Jacksonville, Fla.

WONDERFUL OPPORTUNITY: Well equipped office in metropolitan area almost sure to meet your offer; doctors in building for 15 years. Buy, lease or other consideration for your individual practice. Write 69-71, P. O. Box 1018, Jacksonville, Fla.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Jiminez, Manuel E., Key West

Kaplan, Sherman R., Miami Beach

Kicklighter, James E., Key West

COMPONENT SOCIETY NOTES

Dade

The Dade County Medical Association was recently presented with a citation by the Miami Chamber of Commerce for the work of its members in encouraging employers to hire the physically handicapped. The presentation was made on the program, "Hope Unlimited," over Station WQAM. Physicians are guest speakers on the weekly program which is sponsored by the Chamber of Commerce.

At the September 3 meeting of the Dade County Medical Association, a panel discussion on facial pain was held. Taking part were Drs. Philip Weinstein, Thomas Cook, Kenneth S. Whitmer and Christian Keedy.

Escambia

Escambia county physicians were lauded by *The Pensacola News* in an editorial, Aug. 13, 1952. The newspaper stated that Escambia county surgeons performed 148 operations at Escambia General Hospital during 1951 without charge for their services. "Surgeons take turns in performing these operations, thus carrying on the tradition of the profession that no person in need of medical attention shall suffer because of financial distress." Further it was pointed out: "Too often the unthinking are prone to criticize the medical profession and hospitals for their high fees and charges. They do not stop to figure how costs have risen and what the profesison and the hospitals do to see that medical services and hospitalization is denied no one because of his inability to pay."

Lake

The Lake County Medical Society has paid 100 per cent of state dues for 1952.

Leon-Gadsden-Liberty-Wakulla-Jefferson

The Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society Medical Society will sponsor the Florida Medical Association's Fair Exhibit at the North Florida Fair in Tallahassee, Oct. 27-Nov. 1, 1952. Dr. Francis T. Holland, chairman of the Society's committee on public relations, and Dr. George H. Garmany, both of Tallahassee, are in charge.

Palm Beach

All members of the Palm Beach County Medical Society have paid their state dues for 1952.

Pinellas

The meeting of the Pinellas County Medical Society held on September 5 was the first following the customary recess during the summer months.

The Pinellas County Medical Society is now publishing "The Aesculapian," a reception room supplement to "The Picomeso Mail Bag," the Society's official publication. This section is handy to remove and place in reception rooms to be read by patients.

Seminole

The Seminole County Medical Society's radio program on station WTRR, Sanford, was three years old the last of August, according to announcement by Dr. Orville L. Barks, chairman of the Society's committee on public relations. Transcriptions from the record library of the FMA Bureau of Public Relations have been used for the program.

OBITUARIES

James Covington Richardson

Dr. James Covington Richardson of Miami died on May 25, 1952. He was 58 years of age.

Dr. Richardson was born in 1894. He received his medical training in Nashville, Tenn., and in 1920 was awarded the degree of Doctor of Medicine by the Vanderbilt University School of Medicine. His specialty was surgery. He had practiced in Miami since he came there from Monroe, N. C., in 1932. Locally, he was a member of the Rod and Reel Club and a former member of Harvey Seeds Post of the American Legion. He retained membership in the Baptist Church of Monroe.

A member of the Dade County Medical Association, Dr. Richardson was also a member of the Florida Medical Association for 20 years and held membership in the American Medical Association.

Surviving are the widow, Mrs. Minnie Brooks Richardson; and three sons, James C. Richardson, Jr., Charles H. Richardson and Alfred B. Richardson.

William Benjamin Hopkins

Dr. William Benjamin Hopkins died of a heart attack at his home in Tampa on April 27, 1952. He was 68 years of age.

Born in Franklin County, Virginia, on Dec. 8, 1883, Dr. Hopkins was the first son of William Leftwich Turner and Mary Ella Hopkins. He attended the local schools, the Virginia Polytechnic Institute, and the Medical College of Virginia, from which he was graduated in 1907. He also studied at the University of Vienna in Austria, and while engaged in postgraduate work there served as president of the American Medical Association of Vienna.

Upon entry of the United States into World War I, he enlisted in the Army Medical Corps and from July 1918 to April 1919 served with the American Expeditionary Forces. He was discharged from military service with the rank of major in 1919.

Dr. Hopkins specialized in ophthalmology and otolaryngology. He practiced in Richmond, Va., until 1926, when he moved to Tampa and continued the practice of his specialty there for a quarter of a century. Active in civic and fraternal affairs, Dr. Hopkins was a past commander of USS Tampa Post No. 5, American Legion, and a member and former president of the American Legion Round Table of Hillsborough County. Other affiliations included Sons of Confederate Veterans, Sons of the American Revolution, Society of Colonial Wars, Military Order of the World War, the Stars and Bars, a Military Order, Elks, Knights of Pythias, Hillsborough County Association for the Blind and the Tampa Lions Club, in which he was awarded a life membership for his work in its clinics for the blind. He held membership in the Theta Nu Epsilon and Omega Upsilon Phi fraternities and was also a member of Ye Mystic Krewe of Gasparilla. Active in the Hyde Park Methodist Church, he had served as a member and as chairman of its board of stewards.

Dr. Hopkins was a member of the Hillsborough County Medical Association, the Florida Medical Association and the American Medical Association.

Surviving are the widow, the former Mary C. Nicholson of Littleton, N. C.; one son, Dr. William B. Hopkins, Jr., a lieutenant in the Navy Medical Corps; one daughter, Mrs. Charles S. Heinmiller of Rochester, N. Y.; four brothers, O. L. Hopkins of Richmond, A. H. Hopkins of Rocky Mount, Va., Dr. C. D. Hopkins of Tampa, and Lawson M. Hopkins of Peoria, Ill.; and two sisters, Mrs. D. V. Sabine of Yonkers, N. Y., and Miss Anne Hopkins of Rocky Mount, Va. Three grandchildren also survive.

Leo Henry Riesenbeck

Dr. Leo Henry Riesenbeck of Miami died on June 12, 1952 after being in failing health for some years. He was 48 years of age.

A native of Ohio, Dr. Riesenbeck was born in Cincinnati on Aug. 12, 1903. He received his early education there and was a graduate of Miami University. In 1932, the degree of Doctor of Medicine was conferred upon him by the University of Cincinnati College of Medicine.

Until 1939, Dr. Riesenbeck engaged in the general practice of medicine in Norwood, Ohio. He then spent three years in Barnes Hospital in St. Louis and in Cincinnati General Hospital. In 1942 he was certified by the American Board of Otolaryngology.

After successfully practicing his specialty in Cincinnati for five years, he came to Florida in 1947 because of failing health. After two years his health had improved so much that he was able to enter the general practice of medicine in Miami, and he anticipated resuming his specialty. Within a year, however, after his retirement in 1951 this seasoned clinician, experienced specialist and skillful surgeon lost his battle against disease.

Dr. Riesenbeck was a member of the Dade County Medical Association. He became a member of the Florida Medical Association in 1950 and for the last two years had held honorary status. He also was a member of the American Medical Association.

Adrian Colonna Coogler

Dr. Adrian Colonna Coogler died at his home in Brooksville on June 18, 1952 after a short illness. He was 67 years of age.

The son of Col. and Mrs. Theodore S. Coogler, who came to Brooksville from Manning, S. C., in the eighteen-seventies, Dr. Coogler was born in Brooksville in 1884. He attended local schools and received his medical education in Virginia. In 1907, he was awarded the degree of Doctor of Medicine by the Medical College of Virginia at Richmond.

Returning to his birthplace to reside, Dr. Coogler engaged in the general practice of medicine in Hernando County for 45 years. At the time of his death he was County Physician. He was a member of the Egypt Temple Shrine, of Tampa, the Woodmen of the World, and the Methodist Church.

Dr. Coogler was a member of the Pasco-Hernando-Citrus County Medical Society and had for 35 years been a member of the Florida Medical Association. He was also a member of the American Medical Association.

Surviving are the widow, Mrs. Christine Coogler; one son, Theodore Coogler of Brooksville; one daughter, Mrs. Evelyn C. Kilby of Gainesville; two sisters, Mrs. B. C. Floyd of Brooksville and Mrs. F. I. Roberson of Green Cove Springs; two brothers, F. B. Coogler and J. K. Coogler, both of Brooksville; and one grandson, John Adrian Kilby of Gainesville.

Arthur Jones Logie

Dr. Arthur Jones Logie of Miami died suddenly on June 13, 1950. He was 44 years of age.

Born in New York City in 1907, Dr. Logie pursued his education at Columbia University and the University of Tennessee, and also in Scotland. He attended the Royal Academy of Edinburgh, where he was graduated in medicine in 1933, and also received a degree from the University of Glasgow. He interned in the Edinburgh Royal Infirmary and later in the United Hospital at Port Chester, N. Y. After a residency in the Sea View Hospital in New York City, he became affiliated with the Florida State Hospital at Chattahoochie.

Thereafter, he did research work on the BCG vaccine for the New York City Department of Laboratories at the Willard Parker Hospital until

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

THE COUNCIL-ACCEPTED USES OF

Dramamine®

NOW ARE:

SYMPTOMATIC CONTROL OF NAUSEA AND VOMITING ASSOCIATED WITH	*pregnancy* *therapy with certain drugs (antibiotics, etc.)* *electroshock therapy* *narcotization*
MANAGEMENT OF VERTIGO IN	*Ménière's syndrome* *radiation sickness* *hypertension* *fenestration procedures* *labyrinthitis*
MANAGEMENT OF VESTIBULAR DYSFUNCTION ASSOCIATED WITH	*Streptomycin therapy*

Tablets: 50 mg. each
Liquid: 12.5 mg. in each 4 cc.

—and, of course, MOTION SICKNESS

Dramamine®

BRAND OF DIMENHYDRINATE

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Migraine In Children

"Migraine may appear during the first years of life. The presence of subjective signs, such as headache and flimmer scotoma, is often difficult to determine in young children. The true nature of the symptoms frequently remains obscure for years."

Vahlquist, B. and Hackzell, G.: Acta Paediatrica *38*: 622 (1949).

NO. OF CASES	SEX	AGE AT ONSET	CYCLIC VOMITING	DURATION OF ATTACK	INTENSITY
31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNILATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

(reference given above)

In a study of 400 adult migraine patients, it was revealed that 34% had suffered attacks before the age of 15.* These investigators concluded that childhood migraine was a much greater clinical problem than was previously believed and that psychodynamic mechanisms played an important part in the disease.

These criteria are useful in diagnosis:

Headache attacks with symptom-free intervals plus (at least two of the following) nausea, scintillating scotoma, hemicrania, and hereditary predisposition.

For symptomatic relief in these cases, Cafergot®, N.N.R. (ergotamine with caffeine) may be administered orally. For best results, give adequate dosage promptly.

For children within the age range 7 to 12 years—Cafergot® is administered, one tablet when the attack appears imminent followed by one additional tablet within 30 minutes. Not more than two Cafergot tablets should be administered to children within this age range.

In the adolescent age group, 12 to 18 years of age, the dosage may gradually be increased as necessary up to the usual adult dose, i.e., two tablets when the attack appears imminent followed by one tablet doses at half hour intervals until the attack is aborted. *(Total maximum dose for adults: six tablets for each attack.)*

*Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. *50*: 2269 (Oct.) 1950.

Sandoz Pharmaceuticals
DIVISION OF SANDOZ CHEMICAL WORKS, INC.
68 CHARLTON STREET, NEW YORK 14, N. Y.

1936. At that time he came to Jacksonville to become medical director of the Tuberculosis Division of the Florida State Board of Health, which he organized, and he served in this capacity until 1941. Here he instigated the first mass screening of the people of the state for the detection of tuberculosis, a project which has become nationwide.

Dr. Logie entered the private practice of medicine in Miami in 1941. Already a lieutenant in the United States Army Reserve since 1934, he expected his call to active duty, which, owing to a chronic thrombophlebitis, never came. He did, however, secure active duty as a surgeon in the United States Public Health Reserve, in which he became a captain and served from 1941 to 1950. Locally, he spent much of his time in the cardiac section of Jackson Memorial Hospital and he was active in furthering the development of the Miami Heart Institute, of which he became a director in 1950. He was a Scottish Rite Mason and a Shriner, and enjoyed membership in the Mahi Shrine band.

A member of the Dade County Medical Association, Dr. Logie was also a member of the Florida Medical Association and the American Medical Association. He had been a fellow of the American College of Physicians since 1940 and of the American College of Chest Physicians since 1950 and a member of the American Trudeau Society since 1937. He also held membership in the National Tuberculosis Association and was a diplomate of the American Board of Internal Medicine.

Surviving are the widow, Mrs. Marie Ford Logie, and three sons, Arthur J., Jr., Andrew John and Michael Bruce, all of Miami, and the parents, Mr. and Mrs. Leo L. Logie, and a brother and a sister, all of California.

George Walton Carter

Dr. George Walton Carter of Chipley died on May 5, 1952 at his office following a heart attack. He was 60 years of age.

A native of Georgia, Dr. Carter was born at Lake Park in 1891. He received the degree of Doctor of Medicine from the Maryland College of Eclectic Medicine and Surgery in 1913.

Dr. Carter served in World War I and was honorably discharged with the rank of captain. In 1917, he settled in Caryville, where he served as

physician for two lumber mills. An ardent baseball fan, he organized and managed the Caryville Lumberjacks, a well known area baseball team of several years ago. Since 1937 he had practiced medicine in Chipley. He was a Mason and a Shriner, and a member of the Chipley Methodist Church.

This widely known Washington County physician was serving as president of the Washington-Holmes County Medical Society at the time of his death. For 26 years he had held membership in the Florida Medical Association and he was also a member of the American Medical Association.

Survivors are the widow, Mrs. Maude Davis Carter of Chipley; two foster daughters, Mrs. Mike Toole of Graceville and Mrs. Alex H. Lewis of Marianna; four sisters, Mrs. Senora Thomas of Plant City, Mrs. Mary Hinely and Mrs. Lucy Brown, both of Howell, Ga., and Mrs. James Turner of Savannah, Ga.; and three brothers, Lewis Carter and Paul Carter, both of Lake Park, Ga., and Haywood Carter of Alva.

Medical Licenses Granted

Dr. Homer L. Pearson, Jr., Secretary of the State Board of Medical Examiners, has reported that of the 247 applicants who took the examinations of the Board, held June 30 and July 1, 1952, in Jacksonville, 220 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 220 successful applicants follow:

Anderson, Katherine Hunter, Winston-Salem, N. C. (Cornell U. 1940)
Anderson, Oliver David, Grand Rapids, Minn. (Coll. of Med. Evangelists 1950)
Andrews, James William, Miami (U. of Maryland 1952)
Andrus, Don Leverett, Pensacola (George Washington U. 1943)
Armbruster, Robert Homer, Springfield, Ill. (Northwestern U. 1951)
Astler, Vernon Benson, East Ann Arbor, Mich. (Temple U. 1949)
Augustus, Charles Anderson, (Col.), Muskogee, Okla. (Howard U. 1949)

Bacon, Alfons R., Chicago, Ill. (U. of Illinois 1921)
Bailey, Taylor Dodge, Kissimmee (U. of Buffalo 1951)
Baker, J. Allen, Chicago, Ill. (U. of Illinois 1951)
Balthrop, John Edward, Jr., Pensacola (Med. Coll. of Alabama 1951)
Barker, Arthur Joseph, Pensacola (U. of Vermont 1948)
Barnes, Zerney Burns, Jr., Jacksonville (Emory U. 1950)
Barrineau, Charles Edward, Cairo, Ga. (Emory U. 1952)
Beeson, James Dennis, Jacksonville (U. of Indiana 1949)
Bennett, David Dresden, Jr., St. Augustine (Northwestern U. 1946)

Advertisement

From where I sit *by* Joe Marsh

Wonder how Miss Gilbert Is in "Histery"?

By now I guess you've heard about the spelling errors in the kids' report cards this week.

A typical card looked like this:

Arithmetic.....B
Geography.....B–
Spelling.....C
Grammer.....B

I don't know if Miss Gilbert, the principal, actually wrote those cards, but she took full responsibility. This morning she got up in the Assembly Hall — before the students — and started writing GRAMMAR with two "a's" on the blackboard 100 times!

From where I sit, I'll bet this makes her even more popular with the students. It's nice to see an expert admit she can make a mistake. Too many so-called "experts" claim they're never wrong on such subjects as what you or I ought to eat . . . how we should practice our profession . . . whether we should enjoy beer or buttermilk. A really wise person never claims to "know all the answers."

Joe Marsh

Copyright, 1952, United States Brewers Foundation

Rx

...FOR BOTH DOCTOR AND PATIENT

• The name Sealtest is your guarantee of rich, wholesome dairy foods—healthful refreshment at its nourishing best.

Southern Dairies

Sealtest

ICE CREAM

Bernstein, Theodore Clark, Levittown, L. I., N. Y. (New York U. 1945)
Biggane, Charles Francis, Jr., Miami (U. of Pennsylvania 1945)
Bilotta, Laurence Alexander, Orlando A. F. Base (St. Louis U. 1935)
Birdsong, Gordon Gilbert, Brewster (U. of Tennessee 1939)
Bissell, Lewis Frederick, Jacksonville (U. of Arkansas 1949)
Blumenfeld, Irving Herman, Brooklyn, N. Y. (Chicago Med. Sch. 1939)
Boucek, Robert Joseph, Miami Beach (U. of Pittsburgh 1943)
Bradley, James Lawrence, Altoona, Pa. (Yale U. 1943)
Bradley, Matthew Henry, Warrington (Ohio State U. 1951)
Brill, Warren Daniel, Silver Spring, Md. (U. of Maryland 1944)
Burley, Lee, Richmond, Va. (U. of Louisville 1947)
Byrd, William McCulloh, West Palm Beach (Emory U. 1952)

Cady, Donald James, Saginaw, Mich. (U. of Michigan 1948)
Cantor, Leonard Carroll, Miami (Med. Coll. of Virginia 1952)
Carpenter, Samuel Louis, Jacksonville (Temple U. 1947)
Carter, John Paul, Ann Arbor, Mich. (George Washington U. 1945)
Chambers, William Norman, East St. Louis, Ill. (Washington U. 1950)
Choisser, John Elder, DeLand (St. Louis U. 1939)
Collins, Thomas Rodney, Orlando (U. of Chicago 1940)
Conrad, Elmer R., Detroit, Mich. (U. of Minnesota 1932)
Cox, Forest William, Dayton, O. (U. of Pennsylvania 1925)
Coy, Francis Matthew, Bay Pines (U. of Louisville 1942)
Cummings, Eugene Heyward, Jacksonville (Columbia U. 1944)

Daniel, Ben Early, Lake Butler (U. of Georgia 1945)
Davis, David Kern, Miami (Georgetown U. 1948)
Davis, John Llewellyn, St. Petersburg (Vanderbilt U. 1932)
Dell, George Alexander, Jr., Gainesville (St. Louis U. 1952)
Deutsch, Irvin, Coral Gables (Dalhousie U. 1938)
Dormon, George, Winter Haven (Med. Coll. of Alabama 1950)
Drake, Robert Eldon, Winter Park (Louisiana State U. 1948)

Eccles, Claude Graham, Staten Island, N. Y. (Tulane U. 1932)
Edwards, Ralph, Miami (Boston U. 1952)
Ehlert, Albert John, Lakeland (Tulane U. 1945)
Elgin, Lee William, Jr., Miami Beach (U. of Maryland 1952)
Emerson, Richard Putnam, Boston, Mass. (Harvard Med. Sch. 1952)

Farrar, Edward Larston, Jr., Charleston, S. C. (Emory U. 1949)
Felder, Louis Homer, Atlanta, Ga. (Emory U. 1946)
Fishbein, Harry, Houston, Tex. (U. of Arkansas 1938)
Fisher, John Edward, New Castle, Ind. (U. of Pennsylvania 1943)
Fletcher, John Clyde, Greensboro (Emory U. 1952)
Flinchum, Darius, Warm Springs, Ga. (U. of Virginia 1944)
Fontaine, William C., Panama City (U. of Buffalo 1942)
Frazier, Calvin Hunter, Huntington, W. Va. (Med. Coll. of Virginia 1951)
Frell, Joseph Calabria, Miami Springs (Ohio State U. 1937)
Friedl, Lois Evelyn, Pensacola (U. of Illinois 1950)

Galison, Louis, Miami (Long Island Coll. of Med. 1931)
Gallagher, James Francis, Jr., Newtonville, Mass. (Tufts Coll. 1947)
Garby, Rodes Carl, St. Petersburg (George Washington U. 1943)

Garrett, Spencer Roberts, Columbus, Ga. (Duke U. 1952)
Gattas, Fred Albert, Chicago, Ill. (U. of Illinois 1945)
Gayden, John Matthew, Orlando (Med. Coll. State of S.C. 1951)
Geiger, Eric Francis, Lake Butler (Tulane U. 1952)
Germain, William McKee, Lantana (U. of Michigan 1921)
Gilbert, Robert Gordon, Tampa (Emory U. 1952)
Glassman, Jacob Abraham, Chicago, Ill. (U. of Illinois 1935)
Golinvaux, C. J., Monroe, Mich. (St. Louis U. 1921)
Graves, Herschel Anderson, Jacksonville (Vanderbilt U. 1948)
Gryte, Lewis Adolph, Queen's Village, N. Y. (Manitoba Med. Coll. 1921)
Guerin, Briant Bowman, Sumter, S. C. (Duke U. 1941)
Guest, Maurice Calvin, Orlando (Coll. of Med. Evangelists 1946)
Gunther, Roy W., Amsterdam, N. Y. (Columbia U. 1931)

Habegger, Myron L., Rockledge (U. of Indiana 1932)
Halpryn, Hillard Jack, New York, N. Y. (Columbia U. 1952)
Harrow, Benedict Richard, Pittsfield, Mass. (Duke U. 1945)
Hartman, Clifford Duane, St. Petersburg (Loyola Sch. Med. 1936)
Hastings, Edward Val, Milwaukee, Wis. (Marquette U. 1944)
Hastings, Lawrence Vaeth, Miami (Johns Hopkins Med. Sch. 1948)
Hatfield, Jack Joseph, Indianapolis, Ind. (Indiana U. 1943)
Herr, Paul Sylvester, Harrisburg, Pa. (Hahnemann Med. Coll.of Phila. 1933)
Hobach, George Bernard, Johnson City, Tenn. (U. of Pennsylvania 1943)
Hobach, John Philip, Johnson City, Tenn. (U. of Pennsylvania 1943)
Hornsby, Aubrey Thomas, Durham, N. C. (Columbia U. 1946)
Howard, Karen, Washington, D. C. (Vienna, 1938)
Huntington, Frederic Sargent, Darien, Conn. (Harvard Med. Sch. 1924)
Huth, Edgar William, Valders, Wis. (U. of Wisconsin 1931)

Jackson, Truxton Lawrence, South Miami (Vanderbilt U. 1940)
Jaffe, Norman, Ft. Campbell, Ky. (New York U. 1946)
Jennings, Erwin Reeves, Milledgeville, Ga. (U. of Maryland 1946)
Jeruss, Edward George, White Plains, N. Y. (U. of Arkansas 1940)
Johnson, Whedon, Baltimore, Md. (Johns Hopkins Med. Sch. 1943)
Jones, Elizabeth Charlotte, Branford (Tulane U. 1952)
Jones, Samuel Thomas, III, Birmingham, Ala. (Tulane U. 1950)

Kartsonis, Apostolos Athos, Starke (Athens, 1937)
Kearns, Walter Melody, Jr., Chicago, Ill. (Johns Hopkins Med. Sch. 1947)
Keese, Harvey, Jr., Oak Ridge, Tenn. (U. of Tennessee 1951)
Kindler, Jack, Miami Beach (Duke U. 1952)

Lahser, Charles Irving, Roseboro, N. C. (Bowman Gray Sch. of Med. 1946)
Lane, Martin Luther, Humboldt, Tenn. (U. of Tennessee 1950)
Langston, Henry Irwin, Marianna (Tulane U. 1946)
Langston, Richard James, Atlanta, Ga. (Emory U. 1952)
LaRose, William Robert, Tampa (Loyola U. 1952)
Lauth, Edward John, Jr., Cp. LeJeune, N. C. (U. of Pittsburgh 1947)
Lavengood, Russell W., Jr., New York, N. Y. (U. of Louisville 1951)
Lay, Coy Lafayette, Lakeland (U. of Texas 1946)
Lazzopina, Michael Salvatore, Jersey City, N. J. (Georgetown Med. Sch. 1948)

Specialized
LABORATORY SERVICES

Thyroid Activity
determined by
SERUM PROTEIN-BOUND IODINE
a reliable index to presence and course of

Hypo and Hyper Thyroidism
now available routinely.
(12 cc. clotted blood required)

FLAME PHOTOMETRY
A safeguard against

ELECTROLYTE IMBALANCE
by most reliable, rapid instrument.

SODIUM, POTASSIUM AND CALCIUM TESTS
(1.0 cc. serum each test — 24 hrs. service)

URINE 17 KETOSTEROIDS TESTS
Available soon — Micro method 25 cc. required

Containers, instructions and rates on request for physicians and hospitals.
Airmail — Special Delivery Suggested

Research Consulting

SHAW LABORATORIES
1923 14th Ave., So.
Birmingham, Alabama

Office Phone 4-4733 Night Phone 54-5960

CONVENTION PRESS

218 WEST CHURCH STREET
JACKSONVILLE
FLORIDA

Commercial and
Publication
Printing

Lee, John Portmess, St. Petersburg (Washington U. 1941)
Leffall, LaSalle Doheny, Jr., (Col.), Quincy (Howard U. 1952)
Leonard, James Bernard, Clearwater (Jefferson Med. Coll. 1944)
Lerman, Philip Harry, Westbury, N. Y. (U. of Maryland 1944)
Lerner, Lee Wolfe, New York, N. Y. (McGill U. 1919)
Lev, Morris, Miami Beach (Creighton U. 1934)
Lucas, John Richard, Lake City (Western Reserve U. 1941)
Lundell, Edward Sigfrid, Jacksonville (U. of Pittsburgh 1951)
Lyons, Carmine Keith, Durham, N. C. (Duke U. 1946)

Mack, Daniel Elliott, Jacksonville (Syracuse U. 1946)
Mathews, James Richardson, Jacksonville (U. of Cincinnati 1950)
McCanless, James Thomas, Independence, La. (Med. Coll. of Georgia 1952)
McCarthy, Joseph Francis, Jacksonville (Hahnemann Med. Coll. of Phila. 1948)
McClanathan, Donald Eugene, Chicago, Ill. (U. of Illinois 1944)
McCreary, Albert Bordelocque, Jacksonville (U. of Tennessee 1952)
McLaren, John Robert, Jacksonville (Temple U. 1948)
McLeod, Wallace Norman, Atlanta, Ga. (Emory U. 1952)
Medlock, Frederick Eugene, Jr., Decatur, Ga. (Emory U. 1951)
Mendelblatt, David Lee, St. Petersburg (George Washington U. 1927)
Messer, Henry Davis, Madison (Duke U. 1950)
Meyer, George Wright, Jacksonville (Duke U. 1952)
Miller, Neill Davis, Louisville, Ky. (U. of Louisville 1948)
Miller, William Winfred, Jr., Warrington (U. of Wisconsin 1943)
Millikan, William Johnson, Indianapolis, Ind. (Indiana U. 1942)
Mohler, Floyd William, St. Petersburg (Indiana U. 1944)
Monroe, William Daniel, Pensacola (Tulane U. 1950)
Montague, Fairfax Eubank, Durham, N. C. (Emory U. 1952)
Moore, Maurice Roberts, Norwich, Conn. (Queens U. 1929)
Morgan, Bernard Laurence Newlands, Jacksonville (London, 1940)
Morgan, Paul William, Brackenridge, Pa. (U. of Pittsburgh 1944)
Morris, Richard William, Ft. Lauderdale (U. of Vermont 1930)
Mosher, Donald Melvin, Century (Med. Coll. of Alabama 1949)
Mudd, Robert Hiden, Miami (U. of Pennsylvania 1951)
Muir, Ian Wildridge, Birmingham, Ala. (Med. Coll of Alabama 1951)

Neill, John Storts, Inverness (U. of Louisville 1946)
Nelson, John Hall, Birmingham, Ala. (Med. Coll. of Alabama 1950)
Newman, Abe Lowell, Miami (Med. Coll. of Virginia 1951)
Newman, Jerry Irving, Canton, O. (Ohio State U. 1946)
Norby, Richard Gerhard, New Orleans, La. (U. of Minnesota 1946)

Oleson, Dunlap Wrisley, Hinsdale, Ill. (U. of Chicago 1946)
Osterman, Floyd Arthur, Lake City (Northwestern U. 1945)

Packer, Marvin S., Miami Beach (Chicago Med. Sch. 1950)
Parks, Charles Thomas, Warrington (Med. Coll. of Georgia 1951)
Parmley, John Bill, Electra, Tex. (Tulane U. 1946)
Patterson, Charles Archley, Warrington (Tulane U. 1942)
Perkins, William Hale, Jesup, Ga. (Harvard Med. Sch. 1945)
Pfister, Howard Frederick Carl, Cincinnati, O. (U. of Cincinnati 1943)
Porter, Clark Gardner, Three Rivers, Mich. (Washington U. of St. Louis 1935)

Ralyea, John, Paw Paw, Mich. (Wayne U. 1943)
Ramel, William Joseph, Miami Beach (Jefferson Med. Coll. 1945)
Read, John Sturdivant, Brooklyn, N. Y. (Long Island Coll. of Med. 1902)
Reece, John Wesley, Collbran, Ala. (New York U. 1946)
Rhodes, William Minner, Columbus, O. (U. of Cincinnati 1941)
Rickerd, Charles Lloyd, Milton (Northwestern U. 1941)
Robelen, Harry Charles, Jr., Triangle, Va. (Med. Coll. of Virginia 1942)
Rollings, Harry Evan, Savannah, Ga. (Tulane U. 1943)
Romoser, William Carl, Columbus, O. (Ohio State U. 1935)
Rosenbaum, Irving Henry, Lake City (Columbia U. 1934)
Rubenstein, Eli, Cincinnati, O. (U. of Cincinnati 1946)
Rumberger, Wilson Allen, Pittsburgh, Pa. (U. of Pittsburgh 1950)
Sall, Walter Gerald, Miami Beach (New York U. 1952)
Schadel, Lees Malcolm, Jr., Ft. Lauderdale (Hahnemann Med. Coll. of Phila. 1941)
Scheribel, Karl, Ft. Lauderdale (Loyola Med. Sch. 1931)
Schimek, Robert Alfred, Baltimore, Md. (Johns Hopkins Med. Sch. 1950)

Ambulance Service

FERGUSON FUNERAL HOME
H. E. Ferguson, Licensed Director
1201 South Olive
WEST PALM BEACH, FLA.

• In MIAMI SANITARIUM

Medical Hospital American Plan Hotel for Patients and their families. REST, CONVALESCENCE, ACUTE and CHRONIC MEDICAL CASES. Elderly People and Invalids. *FREE Booklet!*

Acres Tropical Grounds, Delicious Meals, Res. Physician, Grad. Nurses, Dietitian.

SUN-RAY PARK HEALTH RESORT

Mild Mental Cases, Drug and Alcoholics in Separate Building

Schlapik, Daniel David, Miami Beach (Northwestern U. 1925)
Seaman, Irvin, Oak Park, Ill. (Chicago Med. Sch. 1945)
Shedd, Robert Harry, Warrington (U. of Pennsylvania 1948)
Shmerling, Abram Carl, Nashville, Tenn. (Vanderbilt U. 1952)
Silver, Abraham, Miami Beach (St. George Med. Coll. 1936)
Simon, Howard M., Jr., Cleveland, O. (U. of Pittsburgh 1951)
Simpson, Forbes Rheaume, Maitland (Temple U. 1952)
Sinatra, Thomas Joseph, Brooklyn, N. Y. (New York U. 1952)
Slagle, David James, Tampa (U. of Tennessee 1951)
Smathers, Charles Ralph, Philadelphia, Pa. (Temple U. 1952)
Smith, William Landon, Henderson, Ky. (U. of Louisville 1949)
Spindler, James Francis, Dunedin (U. of Georgia 1936)
Stewart, Thomas Jones, Century (Med. Coll. of Alabama 1947)
Stuart, Jack Frederic, Coral Gables (Cornell U. 1951)
Sublett, Daniel Voorhees, Lexington, Ky. (U. of Louisville 1927)

Talcott, LeRoy Everett, Jr., Cp. LeJeune, N. C. (Duke U. 1947)
Thompson, James Ellsworth, Chattahoochee (Emory U. 1952)
Thompson, Ramon Converse, Decatur, Ga. (Emory U. 1952)
Thompson, Ronald MacKinnon, West Palm Beach (U. of Chicago 1949)
Thomson, Robert Vail, Coral Gables (U. of Iowa 1942)
Trappolini, Alma, Miami (U. of Tennessee 1949)
Trumbo, Robert Benson, Orlando (Emory U. 1952)
Turner, Oliver Edmonds, Pittsburgh, Pa. (Jefferson Med. Coll. 1936)
Tyor, Malcolm Paul, McRae, Ga. (Duke U. 1946)

Underwood, Charles R., St. Louis, Mo. (Emory U. 1952)
Utkov, Edmund, Memphis, Tenn. (Switzerland 1947)

Vallotton, William Wise, Valdosta, Ga. (Med. Coll. of Georgia 1952)
Vaughan, Edgar Allen, Jr., Tampa (Emory U. 1952)
Vaughn, Arthur Raymond, Jr., Philadelphia, Pa. (Jefferson Med. Coll. 1947)
Virusky, Edmund Joseph, Jesup, Ga. (U. of Maryland 1941)

Wager, William Francis, Bainbridge, Ga. (Emory U. 1951)
Waldron, Barzillia Robbins, Brookline, Mass. (New York Med. Coll. 1945)
Walker, Gilbert Harold, Key West (Tulane U. 1952)
Walker, Harry Leigh, Gainesville (Temple U. 1952)
Weber, Henry Charles, Drexel Hill, Pa. (Marquette U. 1914)
Weisberg, Abraham Allen, Detroit, Mich. (Detroit Coll. of M. & S. 1932)
Welebir, Andrew John, Falls Church, Va. (Coll. of Med. Evangelists 1939)
Wessel, George Henry, V, Miami (Temple U. 1952)
Whitaker, Jo Anne, Winter Haven (Bowman Gray Sch. of Med. 1952)
White, Gilbert H., Jr., Lynch, Ky. (U. of Illinois 1951)
Wiswell, Orville Otto, Miami (St. Louis U. 1952)
Whitten, Samuel Biscow, Jacksonville (Tulane U. 1952)
Wolf, Earl George, Pensacola (U. of Illinois 1941)

Young, Corbin Alfred, New Orleans, La. (Tulane U. 1952)

Zavertnik, Joseph James, Coral Gables (Johns Hopkins Med. Sch. 1943)

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting October 6, October 20, November 3. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting October 20. Surgical Anatomy & Clinical Surgery, Two Weeks, starting November 3. Surgery of Colon & Rectum, One Week, starting October 20, November 17. Gallbladder Surgery, Ten Hours, starting October 20. Bronchoscopy, One Week, by appointment. General Surgery, One Week, starting October 6. General Surgery, Two Weeks, starting October 6. Breast & Thyroid Surgery, One Week, starting October 6. Esophageal Surgery, One Week, starting October 13. Thoracic Surgery, One Week, starting October 20. Fractures & Traumatic Surgery, Two Weeks, starting October 6.

GYNECOLOGY—Intensive Course, Two Weeks, starting October 20. Vaginal Approch to Pelvic Surgery, One Week, starting November 3.

OBSTETRICS—Intensive Course, Two Weeks, starting September 29, November 3.

MEDICINE—Intensive General Course, Two Weeks, starting October 13. Gastroenterology, Two Weeks, starting October 27. Gastroscopy & Gastroenterology, Two Weeks, starting November 3.

CYSTOSCOPY—Ten-Day Practical Course starting every two weeks.

DERMATOLOGY—Intensive Course, Two Weeks, starting October 13.

Teaching Faculty:

Attending Staff of Cook County Hospital

Address: Registrar, 707 South Wood Street
Chicago 12, Illinois

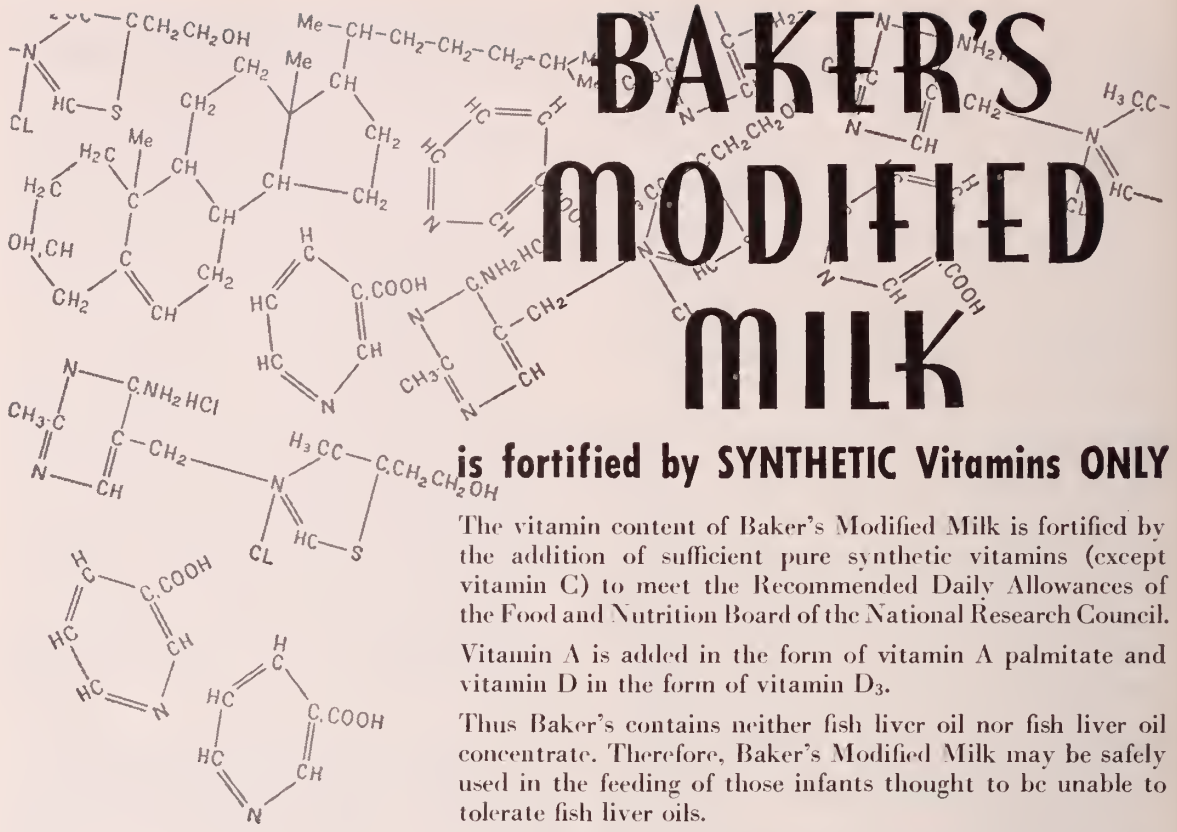
BRAWNER'S SANITARIUM

Established 1910

SMYRNA, GEORGIA
(Suburb of Atlanta)

For Nervous and Mental Disorders
Drug and Alcohol Addiction
Electro-Shock in selected cases

JAMES N. BRAWNER, M.D., Medical Director
ALBERT F. BRAWNER, M.D., Department for Men
JAMES N. BRAWNER, JR., M.D., Department for Women



BAKER'S MODIFIED MILK

is fortified by SYNTHETIC Vitamins ONLY

The vitamin content of Baker's Modified Milk is fortified by the addition of sufficient pure synthetic vitamins (except vitamin C) to meet the Recommended Daily Allowances of the Food and Nutrition Board of the National Research Council.

Vitamin A is added in the form of vitamin A palmitate and vitamin D in the form of vitamin D_3.

Thus Baker's contains neither fish liver oil nor fish liver oil concentrate. Therefore, Baker's Modified Milk may be safely used in the feeding of those infants thought to be unable to tolerate fish liver oils.

Added thiamine and niacin are provided as thiamine hydrochloride and niacinamide, thereby avoiding the digestive disturbances sometimes associated with the use of wheat germ or yeast extracts. Adequate riboflavin is supplied by the milk itself.

Since Baker's contains no vitamin C, an auxiliary source of vitamin C should be prescribed by the physician.

Baker's is ethically promoted and ethically distributed.

* * * * *

POWDER AND LIQUID

AVAILABLE IN DRUG STORES

Baker's Modified Milk is made from Grade A Milk, (U. S. Public Health Service Milk Code) which has been modified by replacement of the milk fat with animal and vegetable fats and by the addition of carbohydrates, vitamins and iron.

VITAMIN CONTENT PER QUART OF NORMAL DILUTION:

Vitamin A	2500 U.S.P. Units
Vitamin D	800 U.S.P. Units
Vitamin C	None
Thiamine	0.6 Milligrams
Niacin	5.0 Milligrams
Riboflavin	1.0 Milligrams

Provides vitamins A and D, also thiamine, niacin, riboflavin, calcium and iron above the minimum daily requirements in the amounts of milk customarily taken by infants. A source of vitamin C should be prescribed by the physician.

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES INC.

Main Office: Cleveland, Ohio
Plant: East Troy, Wisconsin

Division Offices: Atlanta, Dallas, Denver, Greensboro, N. C., Los Angeles, San Francisco, Seattle

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

Camels
lead all
other brands
by billions
CAMEL
TURKISH & DOMESTIC BLEND CIGARETTES
CHOICE QUALITY
CAMEL
TURKISH & DOMESTIC BLEND
CIGARETTES

Allen's Invalid Home

MILLEDGEVILLE, GA.

Established 1890
For the treatment of
NERVOUS AND MENTAL DISEASES

Grounds 600 Acres
Buildings Brick Fireproof
Comfortable Convenient
Site High and Healthful

E. W. ALLEN, M.D., *Department for Men*
H. D. ALLEN, M.D., *Department for Women*
Terms Reasonable

THE EARLE JOHNSON SANATORIUM

For the care of nervous, mental, senile, alcoholic, and addicted cases. **Moderate rates.**

Operated by C. Earle Johnson, Jr., M.D., Psychiatrist-in-Chief, F.A.P.A., F.A.C.P. Diplomate of the American Board of Psychiatry and Neurology.

The most modern and effective psychiatric methods are employed. Gradual reduction in the addictions; Antabuse treatment for alcoholism.

Telephone: 3-3369 or 3-3360
Write: Drawer 106
Meridian, Mississippi

TUCKER HOSPITAL, INC.

212 West Franklin Street

RICHMOND, VIRGINIA

A private hospital accepting for diagnosis and treatment organic neurological conditions, selected psychiatric and alcoholic cases, metabolic disturbances of an endocrine nature, individuals who are having difficulty with their personality adjustments, and children with behavior problems. Patients with general medical disorders admitted for treatment under our staff of visiting physicians.

Under the Professional Charge of
DR. HOWARD R. MASTERS,
DR. JAMES ASA SHIELD AND ASSOCIATES

The Right to *Choose* . . . .

CORNERSTONE OF AMERICAN LIBERTY

Hospital Expense Plans

Medical-Surgical Expense Plans

Paycheck Protection Plans

Life Insurance Plan

AS long as Americans keep the right to choose — their church, their political party, their doctor and their hospital — freedom must prevail.

We are proud that hundreds of thousands of Americans have freely chosen the protection afforded them by PENNSYLVANIA LIFE'S liberal, low-cost health insurance plan.

Pennsylvania Life
HEALTH & ACCIDENT **Insurance Company**

FOUNDED 1890

HOME OFFICE: PHILADELPHIA 5, PA.

19 District Offices in Florida

Miami	Executive Office 3028 Biscayne Blvd.	Fort Lauderdale	521½ South Andrew Avenue
	Downtown 1210 Pacific Building	Jacksonville	303 Clark Building
	Southwest 1260 S. W. 22nd Street	Tampa	228 Cass Street Arcade Building
	Little River 8340 N.E. Second Ave., Suite 245	Sarasota	237 Main Street, Room 15
	Coral Gables 3028 Biscayne Blvd.	Fort Pierce	Florida Bank Building, Room 34
	Miami Beach 206 Harvey Building	Daytona Beach	116½ Orange Avenue
St. Petersburg	509 White Building	Tallahassee	429 Centennial Building
Lakeland	206 Marble Arcade	Panama City	142 Harrison Avenue
West Palm Beach	305 Citizens Building	Pensacola	501 Theisen Building
Orlando	209 Slayton Building		

WHEN DRUG THERAPY

Increases Nutrient Requirements

The administration of many drugs can sharply increase the patient's requirements for various essential nutrients. The presence and action of certain drugs in the organism may alter normal utilization of nutrients to purposes of detoxication of these drugs.

In some instances, drugs may impair absorption of nutrients, increase their destruction within the digestive tract, interfere with their metabolism, or hasten their elimination. With prolonged administration, therefore, unless the intake of various nutrients is increased, deficiency states may be precipitated.

The dietary supplement Ovaltine in milk can significantly increase the nutrient intake of the patient when therapy makes this adjustment necessary. As shown by the table below, it provides substantial amounts of all nutrients known to be essential. Its excellent quality protein furnishes an abundance of all the indispensable amino acids.

Because of its delicious flavor, Ovaltine in milk is universally enjoyed by patients. It is easily digested, bland, and its nutrients are quickly available for utilization. The two varieties of Ovaltine, plain and chocolate flavored, both similar in high nutrient content, allow choice according to flavor preference. Children particularly like Chocolate Flavored Ovaltine.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS				VITAMINS			
*CALCIUM	1.12 Gm.	MAGNESIUM	120 mg.	*ASCORBIC ACID	37 mg.	PYRIDOXINE	0.6 mg.
CHLORINE	900 mg.	MANGANESE	0.4 mg.	BIOTIN	0.03 mg.	*RIBOFLAVIN	2.0 mg.
COBALT	0.006 mg.	*PHOSPHORUS	940 mg.	CHOLINE	200 mg.	*THIAMINE	1.2 mg.
*COPPER	0.7 mg.	POTASSIUM	1300 mg.	FOLIC ACID	0.05 mg.	*VITAMIN A	3200 I.U.
FLUORINE	3.0 mg.	SODIUM	560 mg.	*NIACIN	6.7 mg.	VITAMIN B_{12}	0.005 mg.
*IODINE	0.7 mg.	ZINC	2.6 mg.	PANTOTHENIC ACID	3.0 mg.	*VITAMIN D	420 I.U.
*IRON	12 mg.						

*PROTEIN (biologically complete) ..... 32 Gm.
*CARBOHYDRATE ..... 65 Gm.
*FAT ..... 30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

NEO-IOPAX®

(Sodium Iodomethamate U.S.P.)

A safe urographic contrast medium remarkably free from hazard for the patient.

Pictures without penalties

NEO-IOPAX *urograms and* PRIODAX *cholecystograms*
give definitive information for diagnosing certain pathologic conditions of the urinary and biliary tracts, respectively—without penalty.

PRIODAX®

(Iodoalphionic Acid U.S.P.)

A well tolerated cholecystographic agent, conveniently administered, pleasant to take.

Schering CORPORATION
BLOOMFIELD, N. J.

NEO-IOPAX

SCHERING

PRIODAX

MIAMI MEDICAL CENTER

P. L. DODGE, M.D.
Medical Director and President

1861 N. W. South River Drive
Phones 2-0243 — 9-1448

A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures — Psychotherapy, Insulin, Electroshock, Hydrotherapy, Diathermy and Physiotherapy when indicated. Adequate facilities for recreation and out-door activities. Cruising and fishing trips on hospital yacht.

Information on request
Member American Hospital Association

BISCAYNE HOSPITAL

6339 Biscayne Blvd.
MIAMI 38, FLORIDA

Members of the Dade County Medical Association are acquainted with the high type of service rendered.

David Collins, Superintendent

Registered, American Medical Association
Phone 7-4544

ONE OF AMERICA'S FINEST INSTITUTIONS . . .

BROOK HAVEN MANOR...

with a well trained staff of nurses and attendants, fills the need for a high class, ethical nursing home. Convalescents and elderly patients receive individual attention in these lovely surroundings.

Alcoholics, drug addicts and mental patients are not accepted.

Rates moderate based on individual needs.

Dedicated to the Welfare of the Convalescent and Elderly . . .
. . . . . In a Setting of Inviting Friendliness and Simple Grace. . . Elevation 1200 feet

BROOK HAVEN MANOR SANITARIUM

STONE MOUNTAIN, GA.
MISS ELIZABETH C. HANCOCK, Manager

HIGHLAND HOSPITAL, INC.

FOUNDED IN 1904

Asheville, North Carolina

AFFILIATED WITH DUKE UNIVERSITY

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a sixty-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D.,
Diplomate in Psychiatry
Medical Director

ROBT. L. CRAIG, M.D.,
Diplomate in Neurology and Psychiatry
Associate Director

ESTABLISHED 1911

WESTBROOK SANATORIUM

A private psychiatric hospital employing modern diagnostic and treatment procedures—electro shock, insulin, psychotherapy, occupational and recreational therapy—for nervous and mental disorders and problems of addiction.

Staff

PAUL V. ANDERSON, M.D.
President

REX BLANKINSHIP, M.D.
Medical Director

JOHN R. SAUNDERS, M.D.
Associate

THOMAS F. COATES, M.D.
Associate

R. H. CRYTZER, Administrator

P. O. Box 1514 RICHMOND, VIRGINIA Phone 5-3245

Brochure of Views of our 125-Acre Estate Sent on Request

MIAMI RETREAT SANATORIUM

FOUNDED 1927

For Nervous and Mental Disorders, Alcohol and Drug Addiction

STAFF OF EIGHT NEUROPSYCHIATRISTS
New X-Ray Diagnostic Treatment Facilities
Comfortable AIR-CONDITIONED rooms, suites

79TH STREET AT MIAMI AVENUE
MIAMI 38, FLORIDA
Phone 7-1824

Janet's Nursery for Babies

P. O. Box 191
OSPREY, FLORIDA
Phone RIngling 4-1647

A Nursery for Handicapped Babies

For Information write
H. KEITH JACOBUS
P. O. Box 191
Osprey, Florida

S. A. Kyle — Funeral Director

MEMBER National Selected Morticians BY INVITATION

17 WEST UNION STREET
JACKSONVILLE 2, FLORIDA
Phones 5-3766 5-3767

HILL CREST SANITARIUM

FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

Thoroughly modern in architecture and construction. Eight departments — affording proper classification of patients. All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

James A. Becton, M.D., Physician-in-charge — James Keene Ward, M.D., Associate Physician

P. O. Box 2896, Woodlawn Station, Birmingham, Alabama — Phones 9-1151 and 9-1152

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
lida Medical Association	Robert B. McIver, Jacksonville	Samuel M. Day, Jacksonville	Hollywood, Apr. 26-29, '53
lida Medical Districts	Eugene G. Peck, Jr., Ocala	Council Chairman	
-Northwest	Francis M. Watson, Marianna	Benjamin A. Wilkinson, Tallahassee	Panama City, Oct. 27, '52
-Northeast	William C. Thomas, Jr., Gainesville	Eugene L. Jewett, Orlando	Daytona Beach, Oct. 31, '52
-Southwest	Emmett E. Martin, Haines City	Hugh G. Reaves, Sarasota	St. Petersburg, Oct. 29, '52
-Southeast	Erasmus B. Hardee, Vero Beach	Donald W. Smith, Miami	Ft. Pierce, Oct. 30, '52
lida Specialty Societies			
lemy of General Practice	Edward F. Shaver, Tampa	Frank T. Linz, Tampa	Hollywood, Apr. 26, '53
gy Society	Nelson Zivitz, Miami Beach	Solomon D. Klotz, Orlando	" "
thesiologists, Soc. of	John T. Stage, Jacksonville	Breckenridge W. Wing, Orlando	" "
pter, Am. Coll. Chest Phys	Alexander Libow, Miami Beach	DeWitt C. Daughtry, Miami	"
n. and Syph., Soc. of	Lewis Capland, Miami Beach	Morris Waisman, Tampa	" "
th Officers' Society	George W. Edwards, II, Orlando	Lorenzo L. Parks, Jacksonville	" "
istrial & Railway Surgeons	John H. Mitchell, Jacksonville	William H. Chapman, Jacksonville	" "
rology & Psychiatry	W. Tracy Haverfield, Miami	Roger E. Phillips, Orlando	" "
and Gynec. Society	Dorothy D. Brame, Orlando	J. Champneys Taylor, Jacksonville	" "
thal & Otol., Soc. of	Joseph W. Taylor, Sr., Tampa	Carl S. McLemore, Orlando	" "
opedic Society	Arthur H. Weiland, Coral Gables	Edward W. Cullipher, Miami	" "
ologists, Society of	Robert J. Poppiti, Miami Beach	Alfred E. Cronkite, Fort Lauderdale	" "
atric Society	Egbert V. Anderson, Pensacola	J. K. David, Jr., Jacksonville	W. Palm Beach, Nov. 8-9, '52
tologic Society	Alex. E. Rosenberg, Miami Bch.	George Williams, Jr., Miami	Hollywood, Apr. 26, '53
iological Society	Thomas H. Lipscomb, Jacksonville	A. Judson Graves, Jacksonville	" "
logical Society	George H. Putnam, Gainesville	David W. Goddard, Daytona Beach	" "
Fida—			
isic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Oct. 25, '52
lood Banks, Association	Donald W. Smith, Miami	Mr. J. M. Potts, Miami	Miami, May, 1953
lue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Daytona Beach, Nov. 16, '52
lue Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Mother Loretto Mary, Tampa	Hollywood, Apr. 26, '53
ancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	
ental Society, State	W. G. McLeod, D.D.S., Pensacola	Coleman Brown, D.D.S., Tampa	St. Petersburg, Apr. 20-23, '53
eart Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
ospital Association	Mother Loretto Mary, Tampa	Tracy B. Hare, Miami	Daytona Bch., Nov. 17-19, '52
edical Examining Board	Ralph B. Spires, DeFuniak Springs	Homer L. Pearson, Jr., Miami	Jacksonville, Nov. 23-25, '52
edical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
urses Association, State	Miss Undine Sams, Miami	Bertha King, Tampa	St. Petersburg, Nov. 14-16, '52
harmaceutical Association, State	Mr. Clyde Morris, Daytona Beach	Mr. R. Q. Richards, Ft. Myers	St. Petersburg, May, '53
ublic Health Association	Mrs. May Pynchon, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Jacksonville, Oct. 9-11, '52
uberculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Elsa B. Conant, Pt. St. Joe	
oman's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	Hollywood, Apr. 26-28, '53
erican Medical Association	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	New York, June 1-5, '53
M.A. Clinical Session	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	Denver, Dec. 2-5, '52
Sthern Medical Association	R. J. Wilkinson, Huntington, W. Va	Mr. C. P. Loranz, Birmingham	Miami, Nov. 10-13, '52
bama Medical Association	B. W. McNease, Fayette	Douglas L. Cannon, Montgomery	Birmingham, Apr. 16-18, '53
rgia, Medical Assn. of	C. F. Holton, Savannah	Mr. Sid Wrightsman, Atlanta	Savannah, May 10-13, '53
S. Hospital Conference	Mr. Norman Losh, Orlando	Mr. D. O. McClusky, Tuscal'sa, Ala.	New Orleans, April 8-10, '53
Stheastern Allergy Assn.	Clarence Thomas, Nashville, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Havana, Cuba, Mar. 26-29, '53
Stheastern, Am. Urological Assn.	William Miner, Covington, Ky.	Sidney Smith, Raleigh, N. C.	Nashville, May, '53
Stheastern Surgical Congress	H. L. Claud, Washington, D. C.	B. T. Beasley, Atlanta	Louisville, Mar. 9-12, '53
f Coast Clinical Society	Alvin L. Stebbins, Pensacola	Dale E. York, Pensacola	Pensacola, Oct. 16-17, '52

ELASTIC RIB BELTS FOR FRACTURED RIBS

More comfortable and efficient than adhesive strapping. Made of the finest quality elastic webbing. Order through your Dealer, or order direct with this ad.

QUANTITY	SIZE	PRICE
	Large Adult	$2.75 ea.
	Adult	$2.50 ea.
	Medium Adult	$2.25 ea.
	Child	$2.00 ea.

Delivered.
Less 10% on orders of 12.

SHIP TO:

LITTLE MFG. CO.

Box 202

WADESBORO, N. C.

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
					Total	Paid	
A	Bay	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	William F. Humphreys, Jr., M.D. 112 E. 3rd Court Panama City		24	100%	
	Escambia *Santa Rosa*	Chas. J. Heinberg, M.D. 109 N. Baylen St. Pensacola	Raymond B. Squires, M.D. 386 Brent Bldg. Pensacola	2nd Tuesday 8:00 P.M.	76	100%	
	Franklin-Gulf	John W. Hendrix, M.D. Port St. Joe	Photis J. Nichols, M.D. Apalachicola	Last Wednesday	7	100%	A-1-54 Francis M. Watson, M.D. Marianna
	Jackson-Calhoun	Albert E. McQuagge, M.D. 207 N. Green St. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	16	
	Walton-Okaloosa	William D. Cawthon, M.D. DeFuniak Springs	Edgar H. Myers, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	100%	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		5	100%	
	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	100%	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	Ernest W. Ekermeyer, M.D. 516 N. Adams St. Tallahassee	George H. Massey, M.D. 204 N. Madison St. Quincy	Quarterly 7:30 P.M.	59	55	
	Suwannee	Edward G. Haskell, Jr., M.D. Branford	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak	1st Saturday 9:30 A.M.	9	100%	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Madison	A. Franklin Harrison, M.D. Madison	Eugene D. Thorpe, M.D. Madison		3	100%	
	Taylor *Dixie, Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	3	100%	233
B	Alachua *Bradford, Gilchrist, Union*	Henry J. Babers, Jr., M.D. Box 709 Gainesville	Raymond S. Camp, M.D. 907 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	49	48	
	Duval *Clay*	Ferdinand Richards, M.D. 508 Greenleaf Bldg. Jacksonville	Joseph A. J. Farrington, M.D. 415 Greenleaf Bldg. Jacksonville	1st Tuesday 8:15 P.M.	255	243	
	Marion *Levy*	Carl S. Lytle, M.D. 1206 E. Ocklawaha Ave. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	30	26	B-3-54 William C. Thomas, Jr., M.D. Gainesville
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	11	100%	
	Putnam	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	Bennie J. Massey, M.D. Box 105 Palatka	2nd Tuesday 6:00 P.M.	10	9	
	St. Johns	Charles C. Grace, M.D. 145 King St. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
	Brevard	James A. Sewell, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	23	21	
	Lake *Sumter*	Robert H. Montgomery, M.D. Mount Dora	J. Basil Hall, M.D. Mount Dora	1st Wednesday 7:30 P.M.	26	100%	B-4-53 Eugene L. Jewett, M.D. Orlando
	Orange *Osceola*	Carl S. McLemore, M.D. 1217 Kuhl Ave. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	155	149	
	Seminole	Julian N. Tolar, M.D. First Street Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	16	100%	
	Volusia *Flagler*	J. Richard West, M.D. 224 S. Palmetto Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	78	77	668
C	Hillsborough	Sherman B. Forbes, M.D. 409 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	175	169	
	Manatee	John E. Granade, M.D. 114 Walcaid Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	18	16	
	Pasco-Hernando- Citrus	William H. Walters, Jr., M.D. Lacoochee	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	16	100%	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Pinellas	John P. Rowell, M.D. 2500 Driftwood Rd., S. E. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Mon. Even Mo. 1st Fri. Odd Mo. 6:00 P.M.	190	186	
	Sarasota	Henry G. Morton, M.D. 555 Golf St. Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	2nd Tuesday 8:30 P.M.	44	100%	
	DeSoto-Hardee- Highlands- Glades	Harold S. Agnew, M.D. 705 E. Oak St. Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	26	23	
	Lee-Charlotte- Collier-Hendry	John S. Stewart, M.D. Lee Memorial Hosp. Fort Myers	Harvie J. Stipe, M.D. 210 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	24	23	C-6-54 Emmett E. Martin, M.D. Haines City
	Polk	Ivan W. Gessler, M.D. 402 Professional Bldg. Winter Haven	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	92	89	585
D	Indian River	P. T. McClellan, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	6	
	Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Drive West Palm Beach	David A. Newman, M.D. 511 Citizens Bldg. West Palm Beach	3rd Monday 8:00 P.M.	116	100%	D-7-54 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie- Okeechobee- Martin	Richard F. Sinnott, M.D. 209 Koblegard Bldg. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	15	13	
	Broward	Lloyd U. Lumpkin, M.D. 918 E. Las Olas Blvd. Ft. Lauderdale	William K. Peck, M.D. 915 N. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	82	78	
	Dade	Ralph S. Sappenfield, M.D. 630 duPont Bldg. Miami	Nelson Zivitz, M.D. 311 Lincoln Rd. Miami Beach	1st Tuesday 8:30 P.M.	614	579	D-8-53 Donald W. Smith, M.D. Miami
	Monroe	James B. Parramore, M.D. Box 326 Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	15	14	849

The Anderson Surgical Supply Co.

Established 1916

Telephone 5-8391
40-42 W. DUVAL STREET
P. O. Box 1799
JACKSONVILLE 1, FLORIDA

Telephone 2-8504
1101-1105 TAMPA STREET
P. O. Box 1228
TAMPA 1, FLORIDA

Telephone 7-4589
21 3rd STREET N.
ST. PETERSBURG, FLORIDA

is pleased to announce its exclusive Florida distributorship of all products of

Cy Laboratories

VINCENT CHRISTINA — DIRECTOR

New Rochelle, New York

A FEW OF THESE ETHICAL PRODUCTS ARE:

OSSONATE — in Collagen Diseases. LIPO-K — in Arteriosclerosis and Vitreous opacities. The MARRO-B SERIES — comprehensive anti-anemia therapy. NIAOCIN — in Sinus Congestion. MYO-X — Hormonal control of cardiac function.

NEW YORK ACADEMY OF MEDICINE
2 E 103RD ST
NEW YORK N Y

J C-E

LACTUM

Mead's liquid formula made from whole milk and Dextri-Maltose

AS NUTRITIONALLY SOUND...

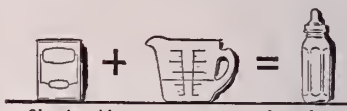
The generous milk protein content of Lactum provides for sturdy growth and sound tissue structure. Dextri-Maltose® supplements the lactose of the milk so that energy needs may be met, fat properly metabolized, and protein spared for its essential functions.

For more than 40 years, milk and Dextri-Maltose formulas with the approximate proportions of Lactum have been used with consistent clinical success. Infants fed Lactum* show good tolerance of feedings, low incidence of digestive disturbances and infections, satisfactory growth response and a generally excellent picture of health and development.

*Frost, L. H., and Jackson, R. L.: J. Pediat., 39:585-592 (Nov.) 1951

AS IT IS CONVENIENT

Mothers appreciate the ease of Lactum's simple 1:1 dilution. It assures accurate measurement. Lactum is ideal also for supplementary and complementary feedings, and whenever single feedings are indicated.



Simply add 1 part Lactum... to 1 part water... for a formula supplying 20 calories per fluid ounce.

MEAD'S

MEAD JOHNSON & COMPANY
EVANSVILLE 21, IND., U. S. A.

Local Representative: Roger J. McElroy, 3181 McDonald Street, Coconut Grove 33, Florida, 4-4124.

NOV 12 1952
LIBRARY

The Journal OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXIX NOVEMBER, 1952 No. 5

IN THIS ISSUE

Symposium on Hypersplenism

Hemolytic Anemia
Sherman R. Kaplan

Management of Thrombocytopenic Purpura
O. Whitmore Burtner

Hypersplenism
William W. Trice, Jr.

Roentgen Examination of Spleen
J. Maxey Dell, Jr.

Splenectomy and Accessory Spleens
George W. Morse

Pathology of Hypersplenism
V. Marklin Johnson

From Our President
Robert B. McIver

OFFICIAL PUBLICATION OF THE
FLORIDA MEDICAL ASSOCIATION

toward a fuller life for epileptics

DILANTIN

DILANTIN Sodium (diphenylhydantoin sodium, Parke-Davis) is supplied in Kapseals® of 0.03 Gm. (½ gr.) and 0.1 Gm. (1½ gr.) in bottles of 100 and 1000.

One university has recently graduated sixteen epileptics from its regular courses.[1] Two have received their Doctor of Philosophy degrees, and three have received their Master of Arts degrees. One is now an assistant professor, another has his own business, and all are gainfully employed.

DILANTIN, termed by many authorities a "drug of choice"[2-5] in *grand mal* and psychomotor seizures, is one of the agents chiefly responsible for such admirable results. Maximum success with DILANTIN is obtained with carefully individualized dosage schedules.

1. Michael, N.: Ohio State M. J. *48*:42, 1952.
2. Carter, S., in Conn, H. F.: Current Therapy 1952, Philadelphia, W. B. Saunders Company, p. 610.
3. Lennox, W. G., in Cecil, R. L., and Loeb, R. F.: A Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Company, 1951, p. 1379.
4. Lennox, W. G., in Piersol, G. M., and Bortz, E. L.: The Cyclopedia of Medicine, Philadelphia, F. A. Davis Company, 1951, Vol. V, p. 215.
5. Christian, H. A.: The Principles and Practice of Medicine, ed. 16, New York, D. Appleton-Century Company, 1947, p. 1370.

MEDICAMENTA VERA

Parke, Davis & Company

DETROIT, MICHIGAN

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

Volume XXXIX NOVEMBER, 1952 No. 5

CONTENTS

SCIENTIFIC ARTICLES

Symposium on Hypersplenism, Steven O. Schwartz, M.D., Moderator 327
Hemolytic Anemia, Sherman R. Kaplan, M.D. 327
Management of Thrombocytopenic Purpura, A Condensed Review, O. Whitmore Burtner, M.D. 330
Hypersplenism — Agranulocytosis and Miscellaneous Manifestations. William W. Trice, Jr., M.D. 334
Roentgen Examination of the Spleen, J. Maxey Dell, Jr., M.D. 337
Technical Aspects of Splenectomy and Location of Accessory Spleens, George W. Morse, M.D. 338
Pathology of Hypersplenism, V. Marklin Johnson, M.D. 341
Discussions on Symposium 344

ABSTRACTS OF MEDICAL ARTICLES

Drs. I. Perlmutter, J. Frank Wilson, Philipp R. Rezek, Milton M. Coplan, Frank M. Woods, Perry D. Melvin and Donald W. Smith 350

EDITORIALS AND COMMENTARIES

Taking Stock 355
Important Court Decision in Hoxsey Cancer Case, 356
Electric Vaporizing Devices for Insecticides Present Health Hazards 357
The Case of Patient Versus Case 357
A. M. A. Coordinating Committee Disbands, Whitaker and Baxter Resign 358
Well Done, Whitaker and Baxter 359
A. M. A. Clinical Session, Denver, December 2-5 359

GENERAL FEATURES

Officers and Committees 352
From Our President 354
Florida Blue Shield 360
Births and Deaths 361
New Members 361
State News Items 361
Wanted — For Sale 364
Component Society Notes 364
Woman's Auxiliary 366
Obituaries 368
Schedule of Meetings 381
List of County Medical Societies, Presidents and Secretaries 382

This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

The Best Tasting Aspirin You Can Prescribe.

Children Take It Without the Least Bit of Fuss

The Flavor Remains Stable Down to the Last Tablet in the Bottle.

24 Tablet Bottle... 2½ gr. each 15¢

2½ gr. 1¼ gr. Grooved Tablets—Easily Halved.

NEW

FLAVORED

CHILDREN'S SIZE

BAYER ASPIRIN

Sig.

Swallowed Whole

Chewed

Dissolved on Tongue

Or in Food Or Liquid

We will be pleased to send samples on request.

THE BAYER COMPANY DIVISION *of Sterling Drug Inc.* 1450 Broadway, New York 18, N. Y.

so many *new* things in this *new* supplement . . .

For almost forty years now the Picker X-Ray Accessories Catalog has been the standard of reference for materials used in radiography, fluoroscopy, and radiation therapy. You will find it on thousands of doctors' bookshelves.

But even in the short time since the last 200-page edition (its fourteenth), Picker has introduced so many new things—the Picker-Polaroid process, for example, which delivers a finished dry radiograph *within a minute after exposure* . . . the Darex FlexiCast "quick-freeze" Immobilizing Cast—*dozens* of things like that—that we now find it necessary to issue a 48-page supplement to include them all.

We'll be glad to send you the supplement if you already have the current Picker Accessory Catalog. Or *both*, if you don't. Either way, you'll keep abreast of recent developments in this eventful field.

Picker x-ray

one source for everything in x-ray

PICKER X-RAY CORPORATION
25 S. Broadway | White Plains, N.Y.

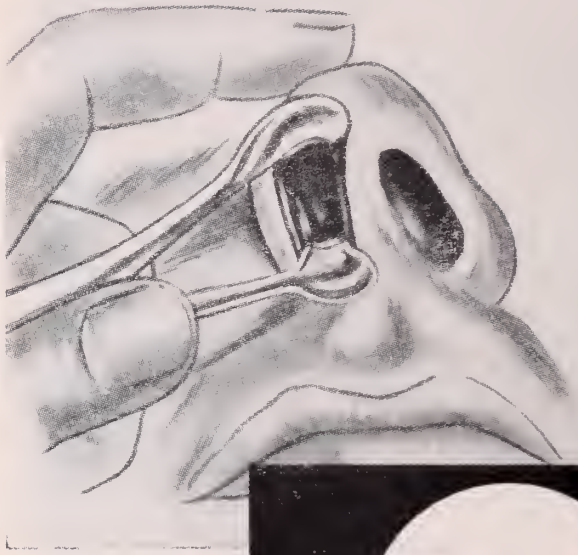
MIAMI 35, FLA., 2759 Coral Way

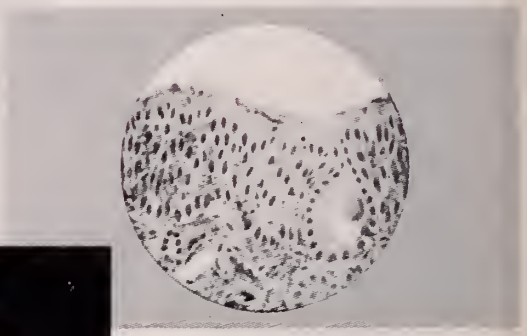
TAMPA 1, FLA., P. O. Box 30

JACKSONVILLE, FLA., 422 W. Duval Street

DON'T MISS Pfizer Spectrum APPEARING REGULARLY IN THE J. A. M. A.

prompt and prolonged decongestion in **COLDS ... SINUSITIS**





Neo-Synephrine hydrochloride, through immediate and prolonged decongestive action, not only restores nasal patency, but also helps to reestablish and protect the physiologic defense mechanisms of the nasal cavity: sinus drainage and aeration.

Neo-Synephrine hydrochloride is notable for its relative freedom from sting and for virtual absence of compensatory congestion. Furthermore, it does not usually produce systemic side effects such as nervous excitation, cardiac reaction or insomnia.

The decongestive action of Neo-Synephrine hydrochloride is undiminished by repeated use—insuring relief throughout the duration of the illness.

¼% solution (plain and aromatic), 1 oz. bottles
½ and 1% solutions (when stronger vasoconstrictive action is needed), 1 oz. bottles
½% water soluble jelly, ⅝ oz. tubes

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Neo-Synephrine®

HYDROCHLORIDE

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

Neo-Synephrine, trademark reg. U. S. & Canada, brand of phenylephrine

"PREMARIN"®

Highly effective • Well tolerated • Imparts a feeling of well-being

"PREMARIN"

Thousands of physicians prefer "Premarin" for the treatment of the menopause.

"PREMARIN"

Estrogenic Substances (water-soluble)

"PREMARIN"

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

also known as Conjugated Estrogens (equine)

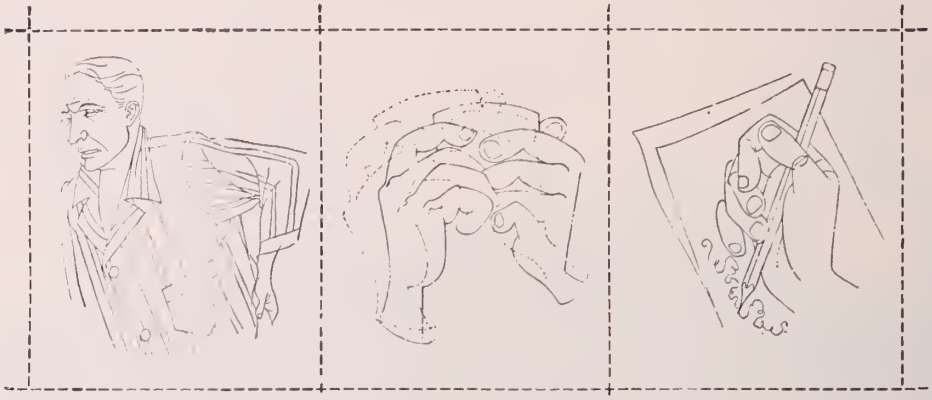
"PREMARIN"

5210

Ayerst®

AYERST, McKENNA & HARRISON Limited • New York, N. Y. • Montreal, Canada

new uniform oral dosage



in muscle spasm of rheumatic disorders

in acute alcoholism

in certain neurologic disorders

The new, uniform oral dose for adults is 1-3 grams. This may be repeated 3-5 times per day.

The first dose prescribed should be at the lower end of the recommended dosage range *(an occasional patient may complain of side effects when* large *doses are given at the* start *of Tolserol therapy).* Subsequent doses may be adjusted to the needs of the individual patient. Whenever possible, Tolserol should be given after meals. When Tolserol is given between meals, it is desirable that the patient first drink ⅓ glass of milk or fruit juice.

Tolserol

Squibb Mephenesin

Tablets, 0.5 Gm. and 0.25 Gm., bottles of 100; *Capsules,* 0.25 Gm., bottles of 100; *Elixir,* 0.1 Gm. per cc., pint bottles; *Intravenous Solution,* 20 mg. per cc., 50 cc. and 100 cc. ampuls.

'TOLSEROL' (REG. U. S. PAT. OFF.) IS A TRADEMARK OF E. R. SQUIBB & SONS

SQUIBB

In early Rheumatoid arthritis

to increase and accelerate the appearance of remissions

"Gold salts, if administered during the first year of rheumatoid arthritis, increase and accelerate the appearance of remissions."* A remission rate of 66 per cent was recently noted in a group of gold-treated patients with rheumatoid arthritis of 12 months or less duration. Similar patients treated without gold showed a remission rate of only 21.1 per cent. On the average, remissions appeared 10 months sooner in the gold-treated cases.

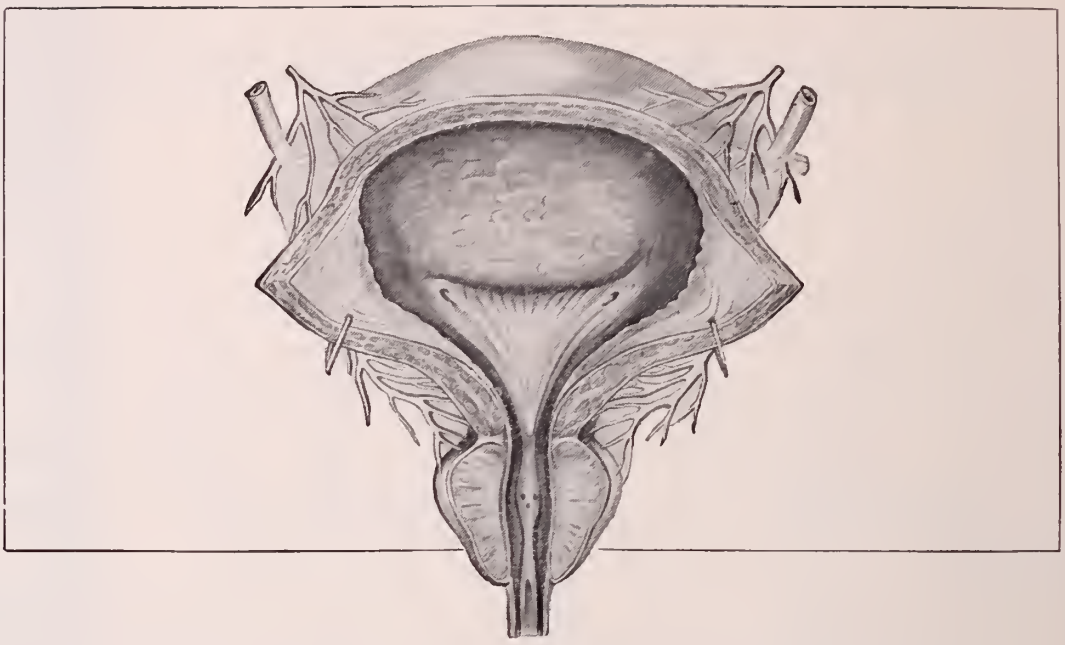
SOLGANAL®
(aurothioglucose)

*Adams, C. H., and Cecil, R. L.: Ann. Int. Med. 33:163. 1950.

Schering CORPORATION • BLOOMFIELD, N. J.

SOLGANAL

SCHERING



Retention Relieved Pharmacodynamically

URECHOLINE® is highly effective in the prevention and control of bladder dysfunction including postoperative urinary retention. It increases muscular tone of the bladder and produces a contraction sufficiently strong to initiate micturition and empty the bladder. Encouraging results also have been reported following the use of URECHOLINE in gastric retention, abdominal distention, and megacolon.

Reprint of recent clinical report available on request

URECHOLINE® Chloride

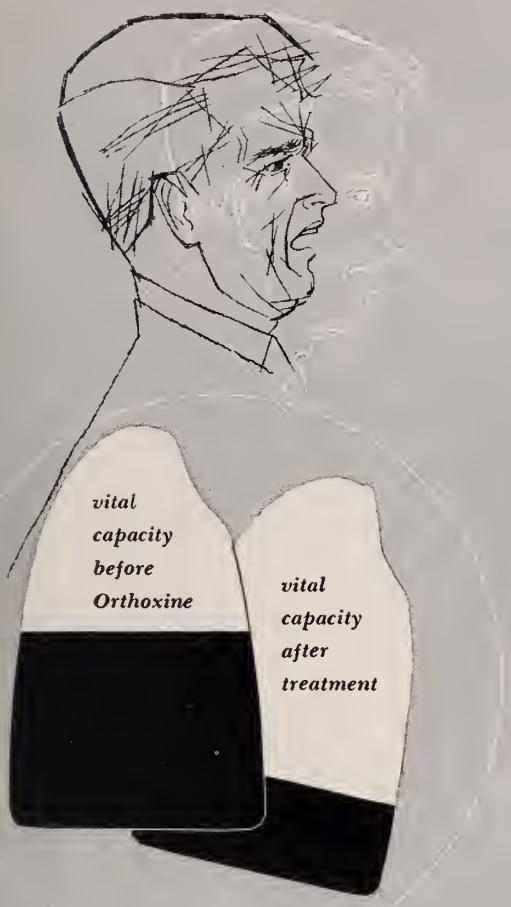
(Bethanechol Chloride Merck)

COUNCIL ACCEPTED

Research and Production for the Nation's Health

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY
In Canada: MERCK & CO. Limited—Montreal

© Merck & Co., Inc.



an answer to asthma

Q. Is there a sympathomimetic agent that will give relief from asthma without causing vasopressor and psychomotor stimulation?

A. Orthoxine Hydrochloride provides bronchodilatation with minimal vasopressor and psychomotor stimulation. By modifying the configuration of a sympathomimetic amine molecule, the action of Orthoxine has been centered mainly upon bronchodilatation, thereby minimizing side-effects arising from vasopressor or psychomotor-stimulating activity.

Orthoxine*

HYDROCHLORIDE

BRAND OF METHOXYPHENAMINE

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Bottles of 100 and 500 tablets.

Orthoxine Hydrochloride (100 mg.) tablets contain *beta-(ortho*-methoxyphenyl)-isopropyl-methylamine hydrochloride, a bronchodilator and antispasmodic.

For Adults: ½ to 1 tablet (50 to 100 mg.)

For Children: half the dose

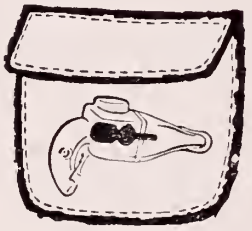
For Both: Repeat every 3 to 4 hours as required

**Trademark, Reg. U. S. Pat. Off.*

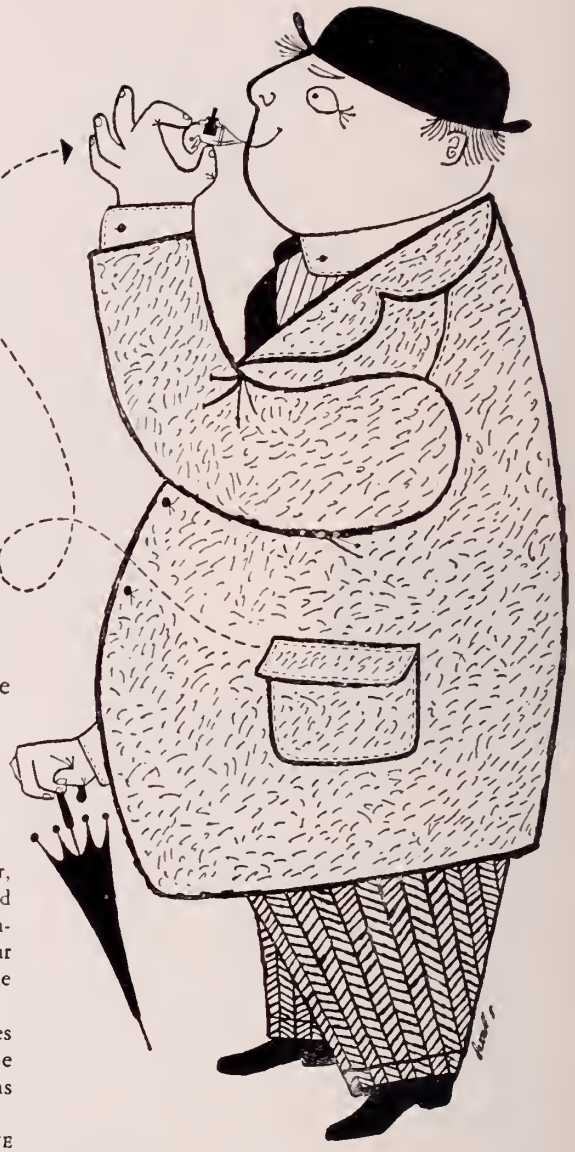
Upjohn *Medicine . . . Produced with care . . . Designed for health*

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

Always ready to abort the Bronchospasm



easy to carry...
in pocket or purse



WITH THIS quick-acting bronchodilating powder, it is now possible for many chronic asthmatics to lead useful, happy lives. When the asthmatic feels a bronchospasm impending he can merely take three or four inhalations of NORISODRINE Sulfate Powder and the attack usually subsides at once.

The patient carries this therapy with him. He uses the AEROHALOR, Abbott's handy, smoke-it-like-a-pipe powder inhaler. No need to leave the job, no injections no cumbersome equipment.

Clinical investigators[1,2,3] have found NORISODRINE effective against both mild and severe asthma. The drug is a sympathomimetic amine with a marked bronchodilating effect and relatively low toxicity. With proper administration, side-effects are few and usually minor.

Before prescribing this potent drug, however, the physician should familiarize himself with administration, dosage and precautions. Professional literature may be obtained by writing Abbott Laboratories, North Chicago, Illinois. Abbott

1. Kaufman, R., and Farmer, L. (1951), Norisodrine by Aerohalor in Asthma, Ann. Allergy, 9:89, January-February.
2. Swartz, H. (1950), Norisodrine Sulphate (25 Per Cent) Dust Inhalation in Severe Asthma, Ann. Allergy, 8:488, July-August.
3. Krasno, L., Grossman, M., and Ivy, A. (1949), The Inhalation of 1-(3',4'-Dihydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust), J. Allergy, 20:111, March.

Norisodrine®

SULFATE POWDER
(ISOPROPYLARTERENOL SULFATE, ABBOTT)

for use with the AEROHALOR®
Abbott's Powder Inhaler

YOUR KEY TO QUALITY

The keystone to the manufacture of all our products is the Production-Control and Research Laboratory. Here, periodic checks are made of every lot as it goes through the various production processes to insure against error and to guarantee the potency and the pharmaceutical elegance of the finished product. Every lot is carefully assayed before packaging or vialing.

YOUR KEY TO THE NEWEST AND LATEST IN DRUG THERAPIES

We have at our disposal one of the largest and finest groups of research facilities and chemists in the industry. In addition to our established line, you may expect new and improved prescription specialities in the near future which will be a welcome addition to your medical armametarium.

KEY CORPORATION

ETHICAL PHARMACEUTICALS

300 NORTH EAST 59th STREET
MIAMI, FLORIDA

FINEST QUALITY YET REASONABLY PRICED TO THE PATIENT

POWDER FORM

The *powder* form of Baker's Modified Milk is suggested for complemental and supplemental feeding because:

1. The powder form may be safely used for an indefinite time after the can has been opened.

2. Individual feedings may be prepared as needed—without the loss of the remainder of the can's contents.

3. Because of the similarity of its fat chemistry to that of human milk fat and its zero curd tension in the stomach of the infant, Baker's is well-tolerated when used as a complemental or a supplemental feeding.

4. Since Baker's powder and liquid are identical except for their physical form, feedings for the infant whose present formula is Baker's Modified Milk *powder* may be changed later to Baker's *liquid* without subjecting the baby to any changes in fat chemistry, protein, mineral balance, etc.

Because of its fat composition, relatively high protein content and extreme flexibility, Baker's Modified Milk powder is especially well-tolerated by the newborn and is particularly helpful in feeding the premature infant.

Both powder and liquid are prepared from high-quality milk* and contain adequate amounts of all known recommended vitamins (except C) as well as sufficient iron ammonium citrate to supply 7.5 milligrams of iron per quart of normal dilution.

Baker's Modified Milk powder is available in one-pound cans. One pound of powder makes approximately four quarts of formula of normal dilution.

Baker's products are ethically promoted and ethically distributed.

* Made from Grade A milk (U. S. Public Health Service Milk Code) which has been modified by replacement of the milk fat with animal and vegetable oils and by the addition of carbohydrates, vitamins and iron.

BAKER'S MODIFIED MILK

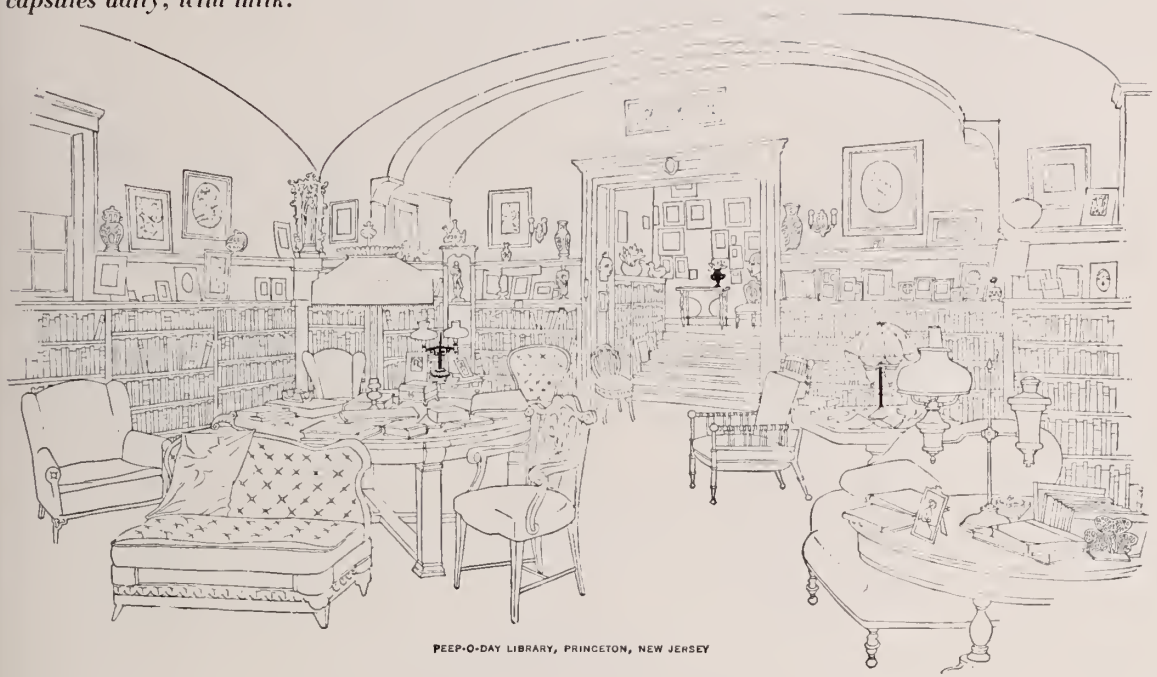
THE BAKER LABORATORIES INC.

Main Office: Cleveland, Ohio
Plant: East Troy, Wisconsin

Division Offices: Atlanta, Dallas, Denver, Greensboro, N. C., Los Angeles, San Francisco, Seattle

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

New aureomycin minimal dosage for adults—four 250 mg. capsules daily, with milk.



PEEP-O-DAY LIBRARY, PRINCETON, NEW JERSEY

a low cost antibiotic in the broad-spectrum field is

AUREOMYCIN

Hydrochloride Crystalline

because

Low dosage of aureomycin has very frequently been reported in the literature to be entirely effective.

Small amounts of aureomycin may reduce disability, or hospital stay, to a few days.

Early use of aureomycin may forestall those failures that have been reported in the literature following penicillin and streptomycin.

The proven range of clinical usefulness of aureomycin is so wide that, when clinical diagnosis is established, prolonged and costly laboratory studies are largely unnecessary.

Capsules: 50 mg.—Vials of 25 and 100.
100 mg.—Vials of 25 and bottles of 100.
250 mg.—Vials of 16 and bottles of 100.

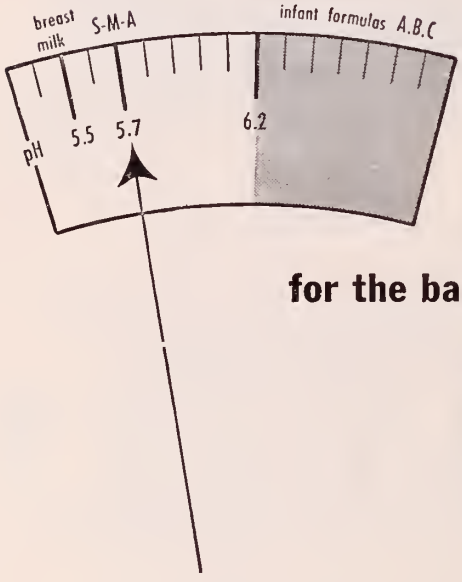
Ophthalmic Solution: Vials of 25 mg.; solution prepared by adding 5 cc. distilled water.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N. Y.

clinical tests show S-M-A®

is the only infant feeding formula that

- establishes a predominantly gram-positive flora—similar to the flora of the lower intestine of the breast-fed baby.[1]



- produces a stool with a pH "practically identical" with that of the infant fed human milk. Stools of babies fed other formulas are distinctly more alkaline (6.2 to 6.7).[1]

for the baby S-M-A means:

1 *Better absorption of minerals, especially calcium.*

2 *Lower incidence of constipation.* Formation of calcium soaps is inhibited; acid produced by fermentation stimulates peristalsis.

3 *Lessened susceptibility to diarrhea.* Lactobacilli inhibit overgrowth of 'colon' group bacilli.

4 *A stool typical of the breast-fed infant*—having a "buttermilk-like", rather than putrefactive odor.

5 *Vitamins more readily available, especially vitamin* B_{12}. Growth of putrefactive organisms which reduce amounts of vitamins available[2] is inhibited.

6 *Minimal danger of perianal dermatitis and diaper rash in the new-born.*[3]

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

REFERENCES

1. Barbero, G.J., Runge, G., Fischer, D., Crawford, M.N., Torres, F. E., and Gyorgy, P.: J. Pediat. *40*:152 (Feb.) 1952.
2. Lichtman, H., Ginsberg, V., and Watson, J.: Proc. Soc. Exp. Biol. and Med. *74*:884 (Aug.) 1950.
3. Torres, F.E., Romans, I.B., and Wheller, J.B.: A Study of Infantile Diaper Rash. To be published.

Wyeth®

Dismayed as she is at the thought of existing without candy and desserts, she is likely to adhere to his diet instructions, for Dr. Harris has a way of encouraging trust in his medical opinion.

Likewise, he has reliance in others whose performance has proved their dependability. He especially favors those who, like himself, go well beyond ordinary demands to serve humanity.

That is one reason why he likes to prescribe the products of a pharmaceutical company which is engaged in . . .

"But Doctor Harris, no sweets?"

Lilly

. . . additional services for diabetics

Aside from having pioneered in the production of Iletin (Insulin, Lilly), Eli Lilly and Company has assumed other wide responsibilities in connection with diabetes. An extensive research program has not only served in the development of improved Insulin preparations but has aided in the dissemination of much significant clinical information. In collaboration with others, a quick, simple, and accurate method of screening blood specimens for the presence of abnormal levels of sugar has been developed. Large-scale diabetes detection has been facilitated. Handbooks, diet sheets, and emergency instruction cards are among the many complimentary services which Eli Lilly and Company is pleased to furnish to physicians as aids in the care of their diabetic patients.

Lilly ELI LILLY AND COMPANY · INDIANAPOLIS 6, INDIANA, U.S.A.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXIX | Jacksonville, Florida, November, 1952 | No. 5

Symposium on Hypersplenism

Moderator, Steven O. Schwartz, M.D.
CHICAGO

Dr. Frederick K. Herpel, West Palm Beach: The afternoon session is devoted to a symposium on hypersplenism. The moderator of this program is an internationally known hematologist, Dr. Steven O. Schwartz, Director of the Hematology Laboratory, The Hektoen Institute for Medical Research, Cook County Hospital, Chicago.

The participants are Dr. Sherman R. Kaplan of Miami Beach, Dr. O. Whitmore Burtner of Miami, Dr. William W. Trice, Jr., of Tampa, Dr. J. Maxey Dell, Jr., of Gainesville, Dr. George W. Morse of Pensacola and Dr. V. Marklin Johnson of West Palm Beach. Inasmuch as the committee had only a skeleton of the symposium, I am going to anticipate as much as I am sure you are, the ramifications of this problem as they are presented. Dr. Schwartz will introduce the various physicians who are to discuss certain features of this symposium, and I will therefore introduce to you now Dr. Steven O. Schwartz of Chicago.

Dr. Schwartz: Thank you very much, sir. When Dr. Patterson originally approached me relative to this symposium, he and his committee had already planned this program rather comprehensively. I think we shall have many different opinions. It is traditional in hematology that every time four hematologists get together there are six opinions. The subject of hypersplenism is a most fascinating one, made more so by the fact that we are gradually broadening our concepts of what it encompasses and learning a little of fundamental mechanisms.

Hemolytic Anemia

Sherman R. Kaplan, M. D.
MIAMI BEACH

The term "hemolytic anemia" encompasses a variety of diseases, among which are included sickle cell anemia, erythroblastosis fetalis, Mediterranean anemia, the hemoglobinurias and congenital and acquired hemolytic icterus. For the purposes of this discussion, the material presented will be limited to those hemolytic anemias characterized by a "hypersplenic" mechanism.

In discussions of abnormal hematologic states, an understanding of the basic normal relationships is an essential prerequisite. Thus it is that in this portion of the seminar I should like to introduce the subject with a brief reference to the normal.

Normal blood values depend on a balance between blood destruction in the periphery and blood formation in the bone marrow. In the peripheral blood of normal persons approximately 1 per cent of the red cells are destroyed each day and simultaneously a similar amount is replaced. This latter situation is reflected by the normal reticulocyte count of approximately 1 per cent.

Hemolytic disease refers to that type of syndrome in which increased destruction of the red blood cells occurs in the peripheral blood. Normal blood values can persist in spite of increased destruction if the rate of destruction does not exceed the compensatory capacity of the marrow to replace the cells as they are being destroyed. Anemia occurs only when there is an imbalance between the blood destruction and blood regeneration. Under such a circumstance the destruction in the peripheral blood proceeds at a rate faster than the maximal regenerative power of the marrow.

Consider for a moment the pathways of normal blood destruction: When the red blood cell has

Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 29, 1952.

reached the end of its life span, it is broken down in the reticuloendothelial system and the spleen into a hemoglobin and a pigment portion. The iron and protein portions of hemoglobin are retained within the body while the pigment portion is excreted into the blood stream as the normal serum bilirubin. The bilirubin is then removed via the liver into the gastrointestinal tract and then reduced and excreted as fecal urobilinogen. A portion of the latter is reabsorbed into the blood stream and re-excreted via the kidney as the normal urinary urobilinogen.

In hemolytic anemia these pathways of normal blood destruction are accelerated. Thus, more red blood cells are destroyed, the process resulting in a greater liberation of bile pigment into the blood stream, an elevation of the icteric index, and a jaundiced patient. More pigment is excreted via the liver into the gastrointestinal tract, the excretion resulting in an increased fecal urobilinogen, and concomitantly more of this is reabsorbed into the blood stream to be excreted via the kidney as an increased urinary urobilinogen. What are the evidences of increased blood regeneration? The first of these is a hyperplasia of the bone marrow, the hyperplasia involving the erythropoietic elements. Secondly, the liberation of red blood cells into the peripheral blood is greatly increased so that one may find the reticulocyte count to be as high as 50 per cent. Furthermore, the normal marrow barriers are broken down in the attempt to compensate for the loss of cells in the peripheral blood, and younger red cells may appear in the form of nucleated red blood cells.

Thus there has been defined the evidences of increased blood destruction on the one hand and the evidences of increased blood regeneration on the other. Elevation of the serum bilirubin and increased fecal and urinary urobilinogen constitute the evidences for increased blood destruction, whereas marrow hyperplasia, elevation of the reticulocyte count and the presence of nucleated red blood cells in the peripheral blood constitute the evidences of increased blood regeneration.

Congenital Hemolytic Icterus

Congenital hemolytic icterus is the first of the "hypersplenic" mechanisms to be discussed. It is a disease which may appear in all gradations of severity. Thus one may find a seriously ill patient with an anemia of the magnitude of 800,000 red blood cells or, contrariwise, an elderly asymptomatic patient with a normal red blood cell count and hemoglobin. As the name implies, the disease is of a familial origin and is transmitted from one of the parents to a variable number of the children. The evidences of increased blood destruction and increased blood regeneration are classical. The patient is icteric and manifests an increased urinary and fecal urobilinogen. The marrow shows an erythroid hyperplasia, and reticulocytosis is a constant finding. The presence or absence of anemia is dependent only on the balance or imbalance between the rate of blood destruction and the ability of the marrow to compensate for it.

An additional feature presents itself at this point which merits some discussion. This is the spherocytic red blood cell which is a sine qua non of congenital hemolytic icterus. The normal red blood cell is a biconcave disk measuring approximately 7.5 microns in diameter. The spherocytic cell, on the other hand, is smaller, measuring approximately 6 microns in diameter, and is more like a golf ball than a biconcave disk. The differences between the two cells may be likened to a completely decompressed balloon as the normal red blood cell and a partially blown up one as the spherocytic red blood cell. The increased hypotonic fragility as seen in all states characterized by spherocytosis then becomes easily understandable. The spherocytic cell being more completely blown up than its normal component will withstand less swelling by a hypotonic solution before it ruptures than the almost completely decompressed normal red cell.

An illustration is afforded by a family with congenital hemolytic icterus, the first of whom to present himself was Kenneth, aged 10. This child entered the hospital with a severe infection of the upper part of the respiratory tract and on admission was found to have a splenomegaly extending to 5 cm. below the left costal margin, an anemia in the magnitude of 3.5 million red cells and 57 per cent hemoglobin, a reticulocytosis of 12.8 per cent and a marrow typical of hemolytic anemia. The hypotonic saline fragility was greatly increased. Two of the siblings, Kathleen, aged 9, and Russell, aged 3, were also studied and were found to have the similar criteria of hemolytic disease. Only Dianne, aged 6, exhibited normal hematologic features. The parents, too, were investigated. The father, aged 52, had worked all of his adult life as a truck driver. Yet he exhibited the classical features of hemolytic icterus, namely splenomegaly to 6 cm. below the left costal margin in the presence of a normal red blood cell count

and hemoglobin, an elevated icteric index, an increased reticulocyte count and a marrow typical of hemolytic anemia. Here, too, the hypotonic saline fragility was greatly increased.

The therapy of congenital hemolytic icterus is splenectomy. This produces uniformly successful results, thus intimately involving the spleen in the pathogenesis of the disease. Evidences of the hemolytic syndrome disappear. This procedure was utilized in the family described with cure resulting in each instance.

Acquired Hemolytic Icterus

The next of the hemolytic syndromes to be discussed is acquired hemolytic icterus. This disease has as its etiology a variety of considerations, among them various chemicals, infections, hemolysins and agglutinins. In addition, the acquired hemolytic anemia may be a "symptomatic" manifestation of underlying disease such as carcinoma, leukemia, lymphosarcoma, Hodgkin's disease, or other illnesses characterized by the presence of splenomegaly. The onset of acquired hemolytic anemia may be fulminating with hemoglobinuria and fever, or less severe and extending over a period of some months. The physical findings reveal the pallor and icterus with a demonstrable splenomegaly present in most of the cases. Here, too, the classic criteria of hemolytic disease are to be found, namely icterus, increased urinary and fecal urobilinogen, marrow hyperplasia, reticulocytosis, and nucleated red blood cells in the peripheral blood. Spherocytosis, too, is a feature of this disease.

Treatment of acquired hemolytic icterus consists in the main of the elimination of the noxious agent, when this is determined, and support of the patient with repeated whole blood transfusions. Splenectomy is not the treatment of choice in this disorder for it is successful in only approximately 40 to 50 per cent of the cases. It is thus held in abeyance, unless, with the elimination of all noxious agents and with the support of whole blood, the patient continues to demonstrate an unsatisfactory clinical course.

Differential Diagnosis

It is pertinent at this point to consider the differential diagnosis between congenital and acquired hemolytic icterus, inasmuch as the classical criteria of blood regeneration and destruction are present in both and since splenomegaly and spherocytosis are features of each disease. The first point in differentiation consists of the study of the family. In congenital hemolytic icterus one or more of the family will manifest the same illness, whereas in acquired hemolytic icterus only the patient will be afflicted with the disease.

The second differential point consists in the performance of the Coombs test. This test is based upon the fact that in acquired hemolytic icterus an abnormal globulin substance coats the red blood cell in the peripheral blood, injuring it, and thus rendering it more susceptible to destruction. In congenital hemolytic icterus, on the other hand, the red blood cells are congenitally abnormal and are delivered this way directly from the marrow. The Coombs test then consists of the exposure of red blood cells from a patient with hemolytic disease to an antihuman globulin rabbit serum. If the cells exposed have been coated with the abnormal globulin substance, the combination with the rabbit serum results in the agglutination of the red blood cells, which may be detected both microscopically and macroscopically. The Coombs test thus gives positive results in most instances of acquired hemolytic icterus and always negative results in congenital hemolytic icterus.

Summary

In conclusion then, one may state that hemolytic icterus is that type of disease characterized by increased destruction of red blood cells. This process elicits a compensatory mechanism on the part of the bone marrow to replace the cells being destroyed. The evidences of destruction are the anemia, increased serum bilirubin, a jaundiced patient, increased fecal and urinary urobilinogen, and spherocytosis. The evidences of blood regeneration are marrow erythroid hyperplasia, reticulocytosis, nucleated red blood cells in the pheripheral blood and splenomegaly.

In congenital hemolytic icterus, splenectomy is 100 per cent successful. In acquired hemolytic icterus splenectomy is successful in approximately 50 per cent of the cases, and therapy should be directed toward elimination of the noxious agents in combination with repeated whole blood transfusions. The Coombs test and study of the families of the patients are the most reliable methods of differentiating congenital and acquired hemolytic icterus.

541 Lincoln Road.

Management of Thrombocytopenic Purpura A Condensed Review

O. WHITMORE BURTNER, M.D.
MIAMI

In this part of the symposium on hypersplenism, I should like to review, within the brief time alloted, some of the practical aspects of management of a patient with thrombocytopenic purpura in its commonly encountered forms.

Thrombocytopenic purpura due to hypersplenism is characterized clinically by petechiae and ecchymoses in the skin and spontaneous hemorrhage into mucous membranes and various tissues. The platelet count is reduced; the bleeding time is prolonged, but the blood clot does not retract; the reaction to the tourniquet test is positive; and the prothrombin consumption is decreased.

A proposed, simplified classification of thrombocytopenic purpura due to hypersplenism is shown in figure 1, and this terminology will be used in this paper. The discussion to follow will conform with the three headings of this classification, namely: (1) Idiopathic Thrombocytopenic Purpura (ITP); (2) Allergic Thrombocytopenic Purpura (ATP); and (3) Hematogenic Thrombocytopenic Purpura (HTP).

Idiopathic Thrombocytopenic Purpura (ITP)

Idiopathic thrombocytopenic purpura is a disease of unknown etiology, occurring most commonly in children and young adults, showing a predilection for the female sex and for the white race, and occasionally demonstrating some degree of familial incidence. The onset and course of the disease are variable, and spontaneous remissions and relapses occur.

The blood smear shows a thrombocytopenia often with variation in the size of the platelets. When severe hemorrhage has occurred, the erythrocytes may show hypochromasia and microcytosis and a temporary leukocytosis with shift to the left of the granulocytes may be present. In a case of long standing there may be a slight relative lymphocytosis and slight leukopenia.

From the Hematology Laboratory and the Department of Medicine of the Jackson Memorial Hospital.
Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 29, 1952.

The bone marrow characteristically shows abnormalities of the megakaryocytes. These cells are increased in number, many of them show immaturity of the nucleus, and the cytoplasm is sometimes scanty, somewhat azurophilic, may be vacuolated, often shows fewer granules than normal and exhibits poor platelet formation. Our moderator, Dr. Schwartz,[1] was the first to direct attention to the practical, prognostic value of the bone marrow eosinophils in idiopathic thrombocytopenic purpura. He and Dr. Kaplan[2] observed that spontaneous recovery or successful splenectomy usually takes place in those cases in which there is sufficient increase in and a shift to the left of the eosinophilic granulocytes, whereas the outlook is less favorable when this eosinophilia fails to occur. I hope that we shall have the pleasure of hearing directly from Dr. Schwartz or Dr. Kaplan as to the prognostic value of marrow eosinophilia as they developed the subject at the Hektoen Institute.

Once the diagnosis of idiopathic thrombocytopenic purpura has been definitely established, consideration should be given to splenectomy in all but those cases considered mild both from the laboratory studies and on clinical grounds, in all but those in which an exacerbation of the disorder proves to be mild and transient and except in those requiring further observation to rule out the possibility of thrombocytopenic purpura due, for example, to a drug sensitivity. In general, in selecting cases for splenectomy the following factors may be important:

1. Drs. Schwartz and Kaplan have pointed out that the presence of a bone marrow eosinophilia of the metamyelocytes and myelocytes augurs for a better than usual response to splenectomy and also indicates a better than average chance for spontaneous improvement.

2. A sizable increase in platelets following the use of ACTH or cortisone would also argue for a favorable result from removal of the spleen.

Classification of Thrombocytopenic Purpura Due to Hypersplenism

(1) Idiopathic Thrombocytopenic Purpura (ITP)
Synonyms: "Primary," "essential," "familial" thrombocytopenic purpura.

(2) Allergic Thrombocytopenic Purpura (ATP)
Synonyms: "Secondary," "symptomatic" thrombocytopenic purpura due to certain chemical, vegetable and animal products, physical agents.

(3) Hematogenic Thrombocytopenic Purpura (HTP)
Synonyms: "Secondary," "symptomatic" thrombocytopenic purpura due to certain blood disorders and diseases associated with splenomegaly.

Figure 1.

3. Certainly in those patients in whom severe hemorrhage develops and who require repeated transfusions, splenectomy should be seriously considered if the diagnosis has been definitely made.

4. Operation should be given greater consideration in women than in men because of the probability of hemorrhage at menstruation and during pregnancy and because recurrences are usually more common in women than men.

5. The potential effects of idiopathic thrombocytopenic purpura should not be underrated. Even in a clinically mild form of the disease, such as in a young woman with little or no menorrhagia, if the platelet count remains consistently under 30,000 per cu. mm. with a borderline prolonged bleeding time, it is believed that splenectomy may be the best prophylaxis available against a possible cerebral hemorrhage later in life.

6. In general, it is probably fair to state that the patient who has had chronic idiopathic thrombocytopenic purpura in mild form for a long period may be expected to respond less well in terms of thrombocytosis and clinical improvement than the patient who has lived with the disorder for a shorter period, but there are exceptions to this rule.

As part of the medical treatment and in order to reduce the risk of hemorrhage associated with surgical therapy, adrenocorticotrophic hormone (ACTH) and cortisone have been tried in a limited number of cases of idiopathic thrombocytopenic purpura. Of patients so treated by Bethell, Miller and Meyers,[3] 1 patient had no remission, in 2 others the remission lasted two weeks and one month, and 4 other patients were still in remission after two weeks, four months, six months and six months, respectively. Although these hormones are worth a trial in this disease, especially when the hemorrhagic tendency is severe, it is thought that they may prove to be of even more value in allergic thrombocytopenic purpura. Transfusions of fresh whole blood, especially of platelet-rich blood, are valuable and often necessary preoperatively.

The effects of ACTH and splenectomy in a case of idiopathic thrombocytopenic purpura are illustrated in figure 2. During administration of ACTH the patient was clinically improved, the platelets slowly increased, the results of the tourniquet test became normal, the bleeding time decreased and clot retraction improved. Following splenectomy, the bleeding time and results of the tourniquet test returned almost immediately to normal, and the platelet count increased rapidly over a period of several days. An average of perhaps between 50 per cent and 80 per cent of patients with this disease may be well five years or more after splenectomy, but the reported results vary rather widely.[4-8] In some series, accessory spleens were found in as many as one third of the cases in which relapse occurred after splenectomy.[8]

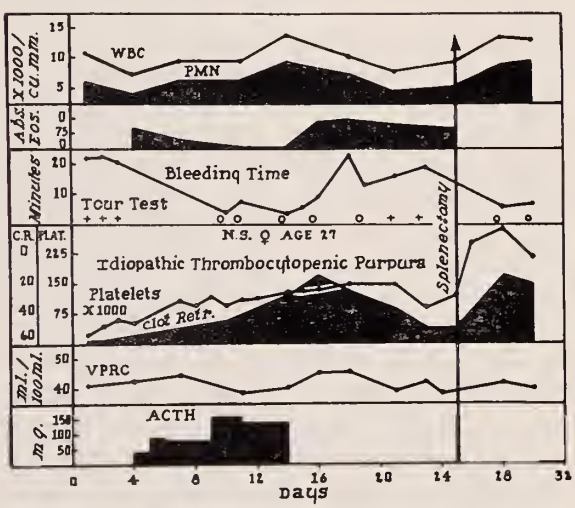


Fig. 2. — Increase in platelet count, reduction of bleeding time and improved clot retraction, all associated with temporary clinical improvement, in a case of idiopathic thrombocytopenic purpura treated with adrenocorticotrophic hormone. The effects of splenectomy are also shown.

Reproduced from M. M. Wintrobe: "Clinical Hematology," ed. 2, by permission of Lea & Febiger, Philadelphia.

That recent important investigations of the pathogenesis of idiopathic thrombocytopenic purpura may eventually contribute to the treatment of this disorder has been stressed in a review by Dameshek.[9]

Evans and his co-workers[9] emphasized the fact that idiopathic thrombocytopenic purpura and acquired hemolytic anemias may occur simul-

taneously in the same patient and that the Coombs test may give positive results in uncomplicated idiopathic thrombocytopenic purpura without hemolytic anemia. Using a platelet agglutination test, these workers demonstrated that this disease is due in many cases to the development of an autoimmune mechanism analogous to that present in acquired hemolytic anemia. Ackroyd[9] reported similar results in thrombocytopenic purpura due to hypersensitivity to sedormid.

Harrington[9] and his co-workers have evidence for a platelet destructive factor, possibly not originating in the spleen, which is present in the blood in some cases of idiopathic thrombocytopenic purpura. When they injected blood or plasma from patients with this disorder into patients with normal platelet counts, thrombocytopenia and a prolonged bleeding time were produced that lasted for several days, and abnormalities in the megakaryocytes of the recipient developed. In the reverse experiment, when platelets in large numbers were injected into the circulation of thrombocytopenic patients, the platelet disappearance time was considerably reduced, thus providing further evidence of a destructive mechanism.

The fact that splenectomy in idiopathic thrombocytopenic purpura often causes the megakaryocytes to produce large numbers of platelets and in some patients results in a rapid cure has led to the postulate of some form of "hypersplenism" as being responsible for this disease, either by a humoral factor acting upon the bone marrow or by excessive sequestration and phagocytosis. The fact, however, that splenectomy does not cure all patients and that the spleen appears relatively uninvolved in certain self-limited cases argues against a splenic factor being operative in every case. These recent reports should stimulate further work on a possible autoimmune mechanism being concerned in the pathogenesis of this disorder.

Allergic Thrombocytopenic Purpura (ATP)

Allergic thrombocytopenic purpura is the acquired form of thrombocytopenic purpura regarded as being due to an allergic or sensitivity reaction,[10] especially to certain chemicals, and also at times to various vegetable and animal products and rarely to some physical agents. A partial list of these possible causative agents is shown in figure 3.

The development of purpura in an adult should arouse suspicion of reaction from a chemical agent rather than of idiopathic thrombocytopenic purpura, which is more common in childhood. Purpura due to drugs often follows the ingestion of a small dose after a short period of abstinence, although the substance may have been taken over many months without deleterious effect. This causal relationship has been well proved by test doses of sedormid,[11] sulfonamides and organic arsenicals in sensitive persons.

Agents Reported as Causing Allergic Thrombocytopenic Purpura (ATP)

(1)	CHEMICALS:	Arsenicals, sulfonamides, quinine, quinidine, sedormid, salicylates, gold salts, iodine, ergot, bismuth, tridione, streptomycin, benzol, certain organic hair dyes, phenobarbital.
(2)	VEGETABLES:	Foods, orris root.
(3)	ANIMAL:	Snake venom, pertussis vaccine, other bacterial products, insect bite, extensive burns.
(4)	PHYSICAL:	Heat stroke, exposure to cold.

Adapted from M. M. Wintrobe: "Clinical Hematology," ed. 2, Philadelphia, Lea & Febiger, 1946.

Figure 3.

The clinical course in a patient in whom purpura develops due to sensitivity from some outside source may be highly variable. Some patients may have a purpura, without thrombocytopenia developing at any time, and this may be mild and transitory or may be more severe and subside only after several weeks. The term nonthrombocytopenic purpura has been used to describe cases of this type, and the names, Henoch's purpura and Schoenlein's purpura, have been applied when gastrointestinal symptoms and joint symptoms, respectively, are associated.

It is with the patients in whom thrombocytopenia develops at some time during the course of the purpura that we are mainly concerned in this discussion of allergic thrombocytopenic purpura. The following abbreviated report of a case illustrates some of the features of the course and management of this disorder.

Report of Case

A 45 year old man was admitted to the Jackson Memorial Hospital for study of a mild purpura, with mild pruritis of three weeks' duration. Two weeks before the onset of the petechiae in the skin he had been given sulfadiazine in therapeutic doses by mouth over a period of three days for a mild infection of the upper part of the respiratory tract. Sulfadiazine had also been given three weeks previously for two days for a similar respiratory infection. There was a history of mild asthma ten years earlier, but the asthma had not recurred, and there was no history of hay fever, hives or food allergies. He stated that his health had always been good. No previous episode of petechiae or any easy bruising tendency had ever been noticed.

The significant findings on examination were a temperature to 99 F., small, discrete petechiae covering all of the skin areas of the body, lymph nodes essentially normal to palpation and no clinical enlargement of the liver or spleen. The hemoglobin, red blood cell count,

platelet count, bleeding time, Lee and White coagulation time and clot retraction time were all initially within normal limits, the white blood cell count was borderline elevated, an eosinophilia of 8 per cent was present, and the tourniquet test gave highly positive results after one minute.

The patient was given pyribenzamine in therapeutic doses, but became progressively worse. The petechiae became much more numerous, and some coalesced to form frank purpuric spots. He became slowly but progressively anemic and slightly jaundiced and was given blood transfusions at decreasing intervals. The spleen tip was felt two weeks after admission, and the spleen slowly and progressively enlarged. A slight generalized adenopathy of the superficial lymph nodes developed. Six weeks after admission, the patient was spiking a temperature to 103 F.; the spleen was down 5 fingerbreadths below the left costal margin; the blood transfusion requirement was about 500 cc. every 10 days, and several febrile transfusion reactions had occurred; the platelet count was down to 20,000 per cu. mm., having commenced a progressive fall to abnormally low levels two weeks after admission; the bleeding time averaged about eight minutes from the finger; clot retraction was delayed; the serum bilirubin was elevated to 3.1 mg. per hundred cubic centimeters; the Coombs test gave positive results; the reticulocyte count was up to 6.5 per cent; there was a leukopenia of about 5,000 white cells per cu. mm. with a consistent eosinophilia of about 6 per cent, and the bone marrow was moderately hyperplastic and showed a definite increase with a shift to the left of the eosinophilic elements with a relative increase in the erythroblast series.

After further transfusions of freshly drawn whole blood, a splenectomy was performed without complication with remission of the febrile course and prompt restoration of the bleeding time and platelet count to normal. This patient was in good health and asymptomatic when last seen five months ago, corresponding to three years and two months after splenectomy.

This report suggests an allergic etiology for this disorder, in this case a sulfonamide, and illustrates the progression of the disease from a nonthrombocytopenic form, which often clears up spontaneously, to a gradually developing thrombocytopenia, and the late development of a pancytopenia, which has been previously reported.[1,2] Had ACTH or cortisone been available, it is conceivable that the process might possibly have been arrested without an operation since these hormones seem to produce their best results in this form of thrombocytopenic purpura. At the least, the use of ACTH or cortisone would have been expected to reduce the potential surgical risk by bringing about substantial improvement both clinically and in the laboratory studies. During the period while the purpura was nonthrombocytopenic, the question of splenectomy did not of course arise, but ACTH might well have been valuable, according to a recent report.[3] During the period of mild thrombocytopenia, splenectomy was withheld since the spontaneous recovery rate is generally acknowledged as being relatively high in allergic thrombocytopenic purpura due, for instance, to drug allergy. Since the thrombocytopenia became progressively acute without remission and hemolytic anemia was a complication, it was believed that, in this particular patient, splenectomy may well have been a life-saving procedure.

Hematogenic Thrombocytopenic Purpura (HTP)

Hematogenic thrombocytopenic purpura is the acquired form of thrombocytopenic purpura due to hypersplenism arising from certain blood disorders and other diseases associated with splenomegaly. Some of these disorders are listed in figure 4.

Blood Disorders and Diseases Associated with Splenomegaly Reported as Causing Hematogenic Thrombocytopenic Purpura (HTP)

(1) Leukemias: All types.
(2) Anemias: Aplastic, osteosclerotic, pernicious.
(3) Splenic Disorders: Banti's syndrome, Gaucher's disease, Felty's syndrome, congenital spherocytosis, acquired hemolytic anemia, Hodgkin's disease.
(4) Infections: Septicemia, subacute bacterial endocarditis, typhus, infectious mononucleosis, tuberculosis.
(5) Miscellaneous: Thrombotic thrombocytopenic purpura, thrombopathic thrombocytopenia, lupus erythematosis disseminatus, sarcoidosis.

Adapted from M. M. Wintrobe: "Clinical Hematology," ed. 2, Philadelphia, Lea & Febiger, 1946.

Figure 4.

In general, thrombocytopenia, with or without anemia and leukopenia, potentially may develop in conjunction with any disease or disorder associated with splenomegaly. A good example would be a patient with lymphatic leukemia of some years standing, with a moderately large or an especially large spleen, in whom there gradually developed an increasing thrombocytopenia and in whom at about the same time there may also have developed a slowly progressive hemolytic anemia.

In managing such a patient with hematogenic thrombocytopenic purpura, in addition to any treatment contemplated for the underlying leukemia, one has the choice, depending upon the circumstances, of (1) relying largely upon fresh whole blood transfusions if the thrombocytopenia and anemia are mild, (2) administering cortisone or ACTH in as small doses as will permit maintenance of adequate levels of the platelets and red blood cells, and (3) performing splenectomy.

Greater recognition has in recent years been given to the value of splenectomy in selected cases of thrombocytopenic purpura associated with lymphoma in which, by definition, the hematogenic thrombocytopenic purpura is due to hypersplenism and not to myelophthisis. In some such cases in which the thrombocytopenia was so severe that it could not be well controlled by ordinary means, splenectomy has often restored the platelet

count to a normal or near normal value and has usually permitted the resumption of treatment with radiation or chemotherapy.

Summary

Salient features of the diagnosis and management of thrombocytopenic purpura due to hypersplenism are briefly reviewed.

A case illustrating the clinical course and treatment of a patient with allergic thrombocytopenic purpura is presented.

The following classification of thrombocytopenic purpura due to hypersplenism is proposed: (1) Idiopathic thrombocytopenic purpura (ITP); (2) Allergic thrombocytopenic purpura (ATP); and (3) Hematogenic thrombocytopenic purpura (HTP).

Since management and prognosis differ considerably in each of these three varieties, exact classification of the thrombocytopenic purpura is essential in each case.

References

1. Schwartz, S. O.: Prognostic Value of Marrow Eosinophils in Thrombocytopenic Purpura, Am. J. M. Sc. 209:579-587 (May) 1945.
2. Schwartz, S. O., and Kaplan, S. R.: Thrombocytopenic Purpura: Prognostic and Therapeutic Value of the Eosinophil Index, Analysis of 100 Cases, Am. J. M. Sc. 219:528-533 (May) 1950.
3. Bethell, F. H.; Miller, S., and Meyers, M. C.: Administration of ACTH and Cortisone in Hypersplenic Syndromes, Proceedings of the Second Clinical ACTH Conference, New York, The Blakiston Company, 1951, vol. 2, pp. 173-180.
4. Dameshek, W., and Estren, S.: Symposium on Specific Methods of Treatment; Hypersplenism, M. Clin. North America 34:1271-1289 (Sept.) 1950.
5. Elliott, R. H. E., Jr., and Turner, J. C.: Splenectomy for Purpura Hemorrhagica, Surg., Gynec., & Obst. 92:539-544 (May) 1951.
6. Bogardus, G., and others: Role of Splenectomy in Thrombopenic Purpura, Arch. Surg. 58:16-27 (Jan.) 1949.
7. Strochel, C. F.; Campbell, D. C., and Hagedorn, A. B.: Problem of Essential Thrombocytopenic Purpura, M. Clin. North America 33:1027-1046 (July) 1949.
8. Wintrobe, M. M.: Clinical Hematology, ed. 3, Philadelphia, Lea & Febiger, 1951, pp. 739-758.
9. Dameshek, W.: The "Humors" and Idiopathic Thrombocytopenic Purpura, Blood 6:954-955 (Oct.) 1951.
10. Madison, F. W.: Role of Allergy in Pathogenesis of Purpura and Thrombocytopenia, Blood 3:1083-1089 (Oct.) 1948.
11. Ackroyd, J. F.: The Pathogenesis of Thrombocytopenic Purpura Due to Hypersensitivity to Sedormid, Clin. Sc. 7: 249-285 (April) 1949.
12. Evans, R. S., and others: Primary Thrombocytopenic Purpura and Acquired Hemolytic Anemia: Evidence for a Common Etiology, Arch. Int. Med. 87:48-65 (Jan.) 1951.

618 duPont Building.

Hypersplenism — Agranulocytosis and Miscellaneous Manifestations

WILLIAM W. TRICE, JR., M.D.
TAMPA

Chronologically, the search for the originator or originators of the concept of abnormal splenic activity is fraught with the usual difficulties encountered in any subject in medical literature about which there has been much controversy. While there is no particular reason from our standpoint at this moment to enter into a discussion over points of historical importance, it seems noteworthy that for nearly 100 years mention has been made of the spleen in association with pathologic states. Gretsel[1] in 1866 is credited with first using the term splenic anemia in describing cases of associated anemia and splenomegaly — a term which Banti, some 30 years later, made popular. Virchow in 1845 indicated relationship of aberrations of formed elements of the blood to the spleen by use of the term "splenomedullary leukemia." As early as 1899, Rendu and Widal, according to Dameshek,[1] suggested that leukopenia might be due to hyperactivity of an enlarged spleen. In 1919, Morawitz and Eppinger[1] suggested the term "hypersplenism" as descriptive of the activities of the spleen when associated with cytopenias. Wiseman and Doan[2,3] in 1939 attracted wide attention by their paper on "Splenic Neutropenia," as did Dameshek in 1941, and Doan and Wright in 1946.

Since 1940, the interest has been progressive in the role of the spleen in abnormal states, such as have been discussed in the two previous papers this afternoon by Drs. Kaplan and Burtner, and in the probable role of the spleen in such conditions as "agranulocytosis" (more correctly, neutropenia) and the leukopenic states, both in association with, and exclusive of, a depression in the peripheral blood of platelets and/or red blood cells.

While the scope and title of this paper limit discussion, it must be borne in mind that the picture of hypersplenism is still controversial. The issues at stake are under constant clinical and research investigation and such that conclusions

Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 29, 1952.

at present must be speculative, hypothetic to a large extent, and subject to constantly changing concepts.

Certainly it seems increasingly evident that it is fallacious to assume that the spleen is, per se, the primary site of disturbance. Even the term "hypersplenism" may, in a few years, seem antiquated and a term such as "hyper-reticuloendotheliosis" be found more suitable.

The division in thinking seems largely to revolve around whether the abnormally acting spleen, that is, the hyperactive organ, phagocytizes red blood cells, white blood cells and platelets, either singly, collectively, or in combination, whether this organ elaborates a hormone or hormones which act directly on the bone marrow to prevent the discharge into the peripheral circulation of one or more of the formed elements of the myeloid tissue, or whether there is a hormonal inhibition of certain elements in the bone marrow. Evidence appears to be accumulating that hormonal influences, whether elaborated under splenic influence or with the spleen simply acting as part "end-organ" of the picture, are present which are capable of producing neutropenia, thrombopenia and anemia, or combinations of these in the peripheral blood.

Neutropenia (a decrease in the granulocytes) is the rule when splenomegaly is present. Exceptions, to be sure, are outstanding, such as certain cases of myeloid metaplasia and polycythemia. Again, however, these latter two syndromes may be part of an interrelated process manifested by myeloproliferation, as suggested by Dameshek.[1]

Hypersplenic Leukopenia

To mention a few disorders in which there not infrequently is encountered leukopenia, one needs only to recall such malignant processes as the leukemias exhibiting at some stage a "sub" or "aleukemic" blood picture, Hodgkin's disease and lymphosarcoma. Not infrequently benign tumors are associated with leukopenia. Gaucher's disease may also have neutropenia as part of its picture, as may disorders in which there is mechanical obstruction of the portal vein or of the splenic vein (for example, thrombosis) and in cirrhosis of the liver. Further, rheumatoid arthritis, Boeck's sarcoid, disseminated lupus erythematosis, all frequently exhibit leukopenia, as do certain infections, notably typhoid, typhus, brucellosis, tuberculosis, syphilis, subacute bacterial endocarditis at times, and others.

The importance to us from a practical standpoint is that there occurs an alteration from the normal blood picture in a myriad of seemingly unrelated disease processes which may have as a common denominator splenomegaly and unusual peripheral blood patterns.

The bone marrow studied by aspiration or biopsy usually reflects a normal or increased granulocytic production that may even be hyperactive in all elements, and therefore is not diagnostic in itself of hypersplenism.

Hypersplenism — Hormonal

Dr. Schwartz[4] in 1937 was the first to demonstrate the experimental production of spherocytes and circulating hemolysins in hemolytic anemia. Recently there has been direct evidence demonstrating a circulating hemolysin in peripheral blood of patients suffering from thrombocytopenic purpura.[5,6] Indirect evidence and inference lead one to suspect similar processes in cases in which leukopenia, cytopenia and neutropenia occur either singly or in combination.

Hypersplenism — Miscellaneous

More bizarre miscellaneous manifestations appear to be a part of this complex mechanism. For example, it is known that with emotional states the spleen has been shown to contract actively, losing volume, (Barcroft, Doan, and others,[7,8]) and concomitantly in the peripheral blood a rise of red blood cells, leukocytes (particularly neutrophils) and platelets occurs. Conversely, there is a prolonged ("permanent?") rise in the peripheral blood of lymphocytes with a relative granulopenia in the postsplenectomy state.

Among other miscellaneous manifestations which, as one may readily see, beggar enumeration, the experimental work revealing the immunoprotective effect of the intact spleen in parabiotic animals to lethal infections is interesting. Jacobson and others[7, 9-11] have rather convincing evidence of the protective effect in rabbits of the intact spleen on inhibition of antibody formation following total body irradiation of sufficient degree to alter all demonstrable hemopoietic tissue (except the protected spleen) and have postulated the presence of circulating protective, humoral (noncellular) substance elaborated by the spleen. Arrowsmith, Tyrone and Lyons[12] noted the preventive effect of major hemorrhage at the time of cesarean section by splenectomy in a patient with idiopathic thrombocytopenic purpura.

Felty's syndrome (neutropenia, splenomegaly and rheumatoid arthritis) has been shown to revert to a normal blood picture following splenectomy. The arthritis remained unchanged.[13]

Volini, Schwartz and their associates[14] followed three patients carefully who were given chloramphenicol in 3 Gm. doses per 24 hours and noted that there was, within a few days, bone marrow hypoplasia, more noticeable in the granulocytic series. They also found maturation arrest in the erythroid elements. The peripheral blood reflected these changes. According to the authors, all changes reverted to normal after the drug was stopped. One wonders in this connection whether such effect was obtained by some interference by the drug of intestinal biosynthesis and subsequent splenic or reticuloendothelial effect, or whether it was due to a direct "toxic" effect of the medication per se.

So-called "periodic (cyclic) neutropenia"[15] may well be another bizarre manifestation of hypersplenism (or "hyper-reticuloendotheliosis"). Splenectomy has been noted as producing benefit by some investigators and no benefit by others.[8,15,16] The interrelationship of so-called thrombotic thrombocytopenic purpura to the "collagen disorders" has been suggested by Meacham and others.[17]

Hypersplenism — Diagnosis

The diagnosis of a functional disorder, and certainly the present subject represents this type, is always difficult. Splenomegaly with normal bone marrow is not sufficient; neither is abnormal bone marrow, with or without splenic enlargement.

The clinician must continue to keep before him the possibility of the development of this syndrome. He must view with suspicious watchfulness, splenomegaly, signs of intravascular blood destruction and leukopenia, whether appearing as sole findings or in combination. Reaction to the Coombs test, which, when positive, has been considered confirmatory evidence of an acquired type of hemolytic anemia,[18] has been observed to change from negative to positive several months after removal of the spleen. Trypsinated red blood cells have been found valuable by Wright and Dodd and their associates[19,20] in demonstrating incomplete hemagglutinins in differentiating between congenital and acquired hemolytic anemias. Cortisone and ACTH do not alter the direction of the Coombs reaction, even though either may exert a beneficial effect upon the intravascular hemolysis. Therapeutically, ACTH and cortisone in preparation for splenectomy or in tiding the patient over a crisis are generally accepted as valuable, if not indispensable aids in the management of the well established case.

Summary

This fascinating and frequently occurring disorder does not appear to involve any one organ system, nor does it seemingly result from any single type of bodily insult. The picture is usually protean, and the therapy not a cure. All cases considered must be judged on individual features and splenectomy reserved for those in which the procedure seems obligatory from a life-saving standpoint. It is never wise to treat the patient on the basis of abnormal laboratory reports alone, and strict skepticism along this line should be the watchword in such cases until more is understood about the abnormal physiology involved.

It is suggested that from a descriptive standpoint, "hyper-reticuloendotheliosis" may be a more exact term than hypersplenism for the aberration of the hemopoietic system discussed in this symposium.

References

1. Dameshek, W., and Estren, S.: Symposium on Specific Methods of Treatment; Hypersplenism, M. Clin. North America 34:1271-1289 (Sept.) 1950.
2. Wiseman, B. K., and Doan, C. A.: Primary Splenic Neutropenia; Newly Recognized Syndrome, Closely Related to Congenital Hemolytic Icterus and Essential Thrombocytopenic Purpura, Ann. Int. Med. 16:1097-1117 (June) 1942.
3. Dameshek, W., and Estren, S.: Hypersplenism: Some Preliminary Observations, Acta. Med. Scandinav. (Supp. 213) 131:106-119, 1948.
4. Dameshek, W.: Hemolytic Mechanisms, Blood, Spec. Issue No. 2, pp. 43-56 (Jan.) 1948.
5. Harrington, W. J.; Minnich, V.; Hollingsworth, J. W., and Moore, C. V.: Demonstration of a Thrombocytopenic Factor in the Blood of Patients with Thrombocytopenic Purpura, J. Lab. & Clin. Med. 38:1-10 (July) 1951.
6. Mueller, J. F.; Ratnoff, O., and Heinle, R. W.: Observations on the Characteristics of an Unusual Circulating Anticoagulant, J. Lab. & Clin. Med. 38:254-261 (Aug.) 1951.
7. Dameshek, W., and Estren, S.: The Spleen and Hypersplenism, A Reprint of an Exhibit Presented at the 100th Anniversary Convention of the American Medical Association, Atlantic City, June, 1947. New York, Grune & Stratton, Inc., 1947.
8. Weiss, H. A., and Collins, W. T.: Chronic Neutropenia; Favorable Response Following Splenectomy, Blood 4:278-282 (March) 1949.
9. Jacobson, L. O., and Robson, M. J.: Factors Effecting X-Ray Inhibition of Antibody Formation, J. Lab. & Clin. Med. 39:169-175 (Feb.) 1952.
10. Jacobson, L. O., and others: Effect of Spleen Protection on Mortality Following X-irradiation, J. Lab. & Clin. Med 34:1538-1543 (Nov.) 1949.
11. Jacobson, L. O.; Robson, M. E.; Marks, E. K., and Goldman, M. C.: The Effect of X-irridation on Antibody Formation, J. Lab. & Clin. Med. 34:1612-1613 (Nov.) 1949.
12. Arrowsmith, W. R.; Tyrone, C., and Lyons, C.: Simultaneous Cesarean Section and Splenectomy in Idiopathic Thrombocytopenic Purpura, J. Lab. & Clin. Med. 34:1580 (Nov.) 1949.
13. Montgomery, M. M., and Grissom, R. L.: Neutropenia and Splenectomy Associated with Rheumatoid Arthritis, Report of Four Cases with Splenectomy, J. Lab. & Clin. Med. 34: 1726-1727 (Dec.) 1949.
14. Volini, I. F., and others: Hemopoietic Changes During Chloromycetin Administration, J. Lab. & Clin. Med. 34:1747-1748 (Dec.) 1949.
15. Remann, H. A., and de Berardinis, C. T.: Periodic (Cyclic) Neutropenia, an Entity. Collection of 16 Cases, Blood 4:1109-1116 (Oct.) 1949.
16. Fullerton, H. W., and Duguid, H. L. D.: A Case of Cyclical Agranulocytosis with Marked Improvement Following Splenectomy, Blood 4:269-277 (March) 1949.
17. Meacham, G. C., and others: Thrombotic Thrombocytopenic Purpura, A Disseminated Disease of Arterioles, Blood 6:706-719 (Aug.) 1951.
18. Singer, K., and Motulsky, A. G.; Developing (Coombs) Test in Spherocytic Hemolytic Anemias; Its Significance for Pathophysiology of Spherocytosis and Splenic Hemolysis, J. Lab. & Clin. Med. 34:768-783 (June) 1949.
19. Wright, C. S.; Dodd, M. C., and Bouroncle, B. A.: Studies of Hemagglutinins in Congenital and Acquired Hemolytic Icterus, J. Lab. & Clin. Med. 34:1768 (Dec.) 1949.
20. Wright, C. S.; Doan, C. A.; Bouroncle, B. A., and Zollinger, R. M.: Direct Splenic Arterial and Venous Blood Studies in the Hypersplenic Syndromes Before and After Epinephrine, Blood 6:195-212 (March) 1951.

620 Citizens Building.

Roentgen Examination of the Spleen

J. Maxey Dell, Jr., M.D.
GAINESVILLE

Clinicians are fully aware of the difficulties of palpating the spleen and evaluating its size. A spleen may be enlarged but not palpable due to obesity, tense or well developed abdominal muscles, a narrow costal angle or, most often, a high diaphragm. The opposite is also true. Palpable spleens may be normal. These spleens are palpable only because of a lax abdominal wall, wide costal angle or, most frequently, a low diaphragm.

In 1946 some 300 patients were studied by posteroanterior roentgenograms of the spleen at Battey General Hospital by Klinefelter and Dell.[1] The patients should be prepared by a laxative and enemas, and the stomach should be empty. Certain criteria were established which were useful, but need some revision. These were stated as follows: The spleen is not enlarged if it is: (a) not visualized, (b) less than 5 cm. in width, and (c) less than 85 per cent the size of the kidney. The spleen is enlarged if it is: (a) more than 6 cm. in width, and (b) more than 85 per cent the size of the kidney. The spleens in the group between these two were evaluated on the basis of density. It was believed that an increase in density signified that the spleen was rotated so that the anteroposterior diameter was increased, which would infer a decrease in width. This point surely must be taken into consideration. We did not use spleen length because of the inability to visualize the upper pole. The diaphragm was shown to be a poor measuring point for the upper end of the spleen.

The ideal would be clear visualization of the outlines of the spleen and left kidney. This would be the equivalent of a height-weight chart. Because of the variations in the normal, it is believed that all spleens below 6 cm. in width, and smaller than the kidney, should be considered normal in size. Spleens over 6 cm. and larger than the kidney should be considered enlarged. The height and weight of the patient and the density of the spleen should be taken into consideration.

We observed 5 patients with small spleens in whom malaria with enlargement of the spleen developed, but the size still fell within the range of normal. These patients had small spleens normally, and if we had seen them first when the small spleens were enlarged, we would have called them normal. In this type of case the size can be determined only by serial films. Eight patients were studied at weekly intervals for one to three months. The effects of exercise, rest and food were studied, and no change in the size of the spleen was noted. Studies on patients with enlarged spleens as the result of malaria showed a definite decrease in the size of the spleen after the administration of adrenalin. These spleens returned to normal after the eradication of the malaria. This method of splenography is simple technically. It is definitely more accurate than palpation and will determine splenic size in a majority of cases.

The problem of the accessory spleen is difficult. Dr. Fred Coe kindly let me have a film showing the demonstration of an accessory spleen by thorotrast. Dr. Coe condemns the administration of thorotrast without reservation. The reason is that in injecting the thorotrast if any of the material leaks into the surrounding tissue, it produces profound effects which in 1 reported case resulted in sarcoma. It is my impression that the risk of thorotrast injection is greater than the diagnostic reward justifies. Dr. Coe stated that in his 10 year follow-up study of the thorotrast cases, no evidence of systemic damage was found. Usually the accessory spleen lies just below the lower end of the spleen.

In cases in which there is a mass in the left upper quadrant of the abdomen, the determination of the organ involved is sometimes easy. A definite notch or a typical appearance will be all the evidence we need at times to state that the mass is spleen. As a general rule, the enlarged spleen does not displace the kidney downward and certainly not laterally or forward. When needed, urograms and gastrointestinal studies are of value.

Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 29, 1952.

The spleen, when enlarged, usually depresses the splenic flexure and indents the greater curvature of the stomach. Usually we can determine whether the mass in the left upper quadrant is spleen or not.

In the diagnosis of splenic enlargement there is still much to be desired. Perhaps some day a material like thorotrast will be safe. In the condition of hypersplenism the determination of enlargement of the spleen is apparently of great importance, and in a considerable number of cases a plain film of the splenic area will determine the size of the spleen accurately.

1. Dell, J. M., Jr., and Klinefelter, H. F., Jr.: Roentgen Studies of Spleen, Am. J. M. Sc. 211:437-442 (April) 1946.

217 South Main Street.

Technical Aspects of Splenectomy and Location of Accessory Spleens

GEORGE W. MORSE, M.D.
PENSACOLA

Time will not permit a detailed discussion of operative technic, but there are certain technical aspects of splenectomy which perhaps should be kept in mind.

The incision used for splenectomy will vary with the individual preference of the surgeon. The longitudinal, such as the upper left rectus or paramedian or Bevan, incision is perhaps the one most often used. The transverse incision which extends from the costal margin toward the midline is used by some. The oblique or subcostal incision or left Kocher incision is excellent in the extremely obese patient. The transthoracic incision gives excellent exposure, but in the cases under discussion today it is not a satisfactory incision as exploration for accessory spleens cannot be adequately carried out. Various combinations of these incisions have been used, perhaps the best one being that of Cole (fig. 1), who starts the incision high in the left portion of the epigastrium, extending it paramedially downward 2 to 3 inches and curving it laterally to the left and parallel to the costal cartilages. The rectus muscle is transversely divided, and enough of the muscles of the anterior abdominal wall are cut to allow adequate exposure. This incision usually results in the sacrifice of only one of the intercostal nerves, and hence no weakening of the abdominal wall will occur. All incisions are concerned, however, with the exposure of the spleen and its pedicle. This is most important in the technical removal of the spleen, for if the incision is adequate and the spleen can be separated from the stomach, the pancreas and the diaphragm and the splenic pedicle ligated under direct vision, operative and postoperative complications will be reduced to a minimum.

If, upon opening the abdomen, the stomach is found to be unduly distended, a Levin tube should be passed, as this will increase the visibility and make the dissection easier unless the spleen is easily deliverable. In cases in which the spleen is large and vascular, the tube should be left in the stomach for a few days to prevent gastric distention which may displace ligatures and lead to fatal hemorrhage.

After a rapid exploration of the abdomen in search of other pathologic conditions, one should carefully inspect and palpate the spleen in order to determine its size and mobility, and the vascularity of the adhesions. It is from information derived thereby that one decides on the proper procedure. Spleens of thrombocytopenic purpura are the easiest to remove since they are not much increased in size and are usually not adherent. If this type spleen should be present and it is not adherent and easily separated at its upper pole (fig. 2), it is probably easier for one to reflect it anteriorly, placing a hot pack up under the diaphragm and proceeding with the ligation of the pedicle. This procedure is, if possible, carried out posteriorly as the veins and tail of the pancreas

Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 29, 1952.

are more easily identifiable than if approached through the anterior portion of the pedicle. One should ligate the vessels separately and doubly, rather than ligating the pedicle en masse, unless emergency bleeding has occurred. Spleens which are enlarged, as in congenital hemolytic anemia, may not be adherent; in this disease they usually are not, and may be removed in the manner described.

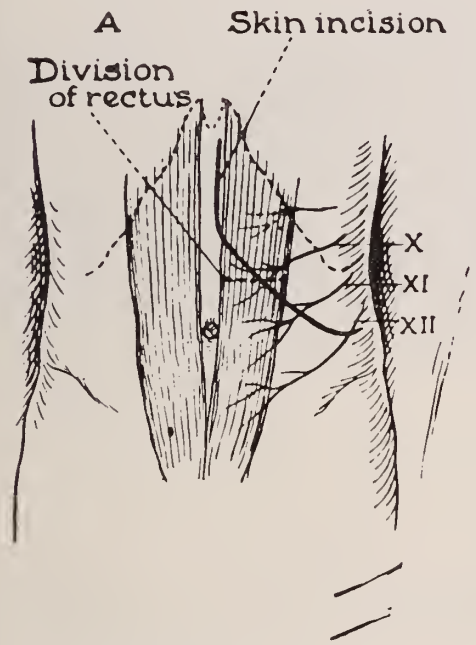


Fig. 1.—The Cole incision.
Courtesy, Cole, W. H. (Editor): Operative Technic in General Surgery, New York, Appleton-Century-Crofts, Inc., 1949, p. 686.

Spleens which are enlarged and adherent, as in Banti's disease, are the most difficult to remove, and it is perhaps here that a deliberate type of splenectomy should be performed. Before any attempt is made to mobilize a spleen of this type, preliminary ligation of the splenic artery is of tremendous value to the surgeon and at times life-saving to the patient (fig. 3). One can ligate it either through the gastrohepatic omentum or by detaching the gastrocolic ligament and turning the stomach upward. This procedure will expose the splenic artery, and it may be ligated near its origin from the celiac axis or it may be ligated through the floor of the lesser peritoneal cavity at the superior edge of the pancreas as it turns toward the spleen (fig. 4). This step is not alone useful in the control of hemorrhage, but in addition primary ligation of this artery will allow blood to flow out gradually from the spleen resulting in an autogenous transfusion. The vascular pressure in the spleen as well as the vascularity of the adhesions will be sharply reduced. If the ligation is performed along the superior border of the pancreas, care should be taken that the splenic vein is not ligated or torn. If it is ligated, the advantages of autogenous transfusion and decrease in vascular pressure will be lost, and if the vessel is torn, troublesome bleeding will occur. Following the preliminary ligation of this artery, the lesser peritoneal cavity is widely opened, and all the vascular and ligamentous attachments should be carefully isolated and a ligature passed around them on an aneurysm needle under direct vision before any attempt is made to deliver the spleen.

In certain cases, because of the patient's condition and the denseness of the adhesions to the diaphragm, Rives, cited by Thorek, advised separation of the parietal peritoneum from the lateral abdominal wall and diaphragm (fig. 5). This is accomplished by displacing the spleen as far as possible medially after division and ligation of all of the adhesions that can be visualized have been done. The parietal peritoneum is then divided along an irregular line anterior to the remaining attachment. Thereby a line of cleavage is opened up that is relatively avascular, and the parietal peritoneum can be stripped easily

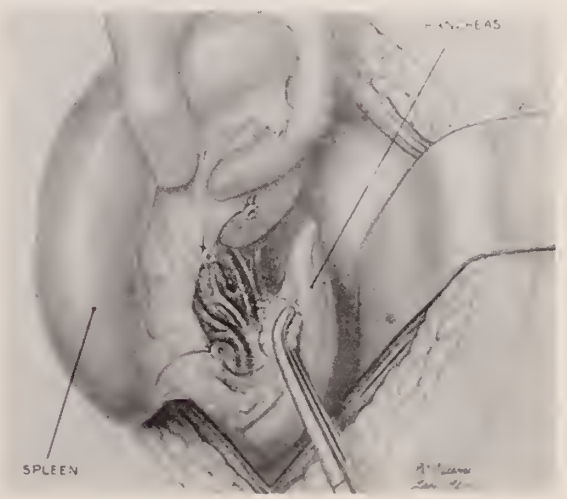


Fig. 2.—The spleen has been reflected anteriorly and the vessels of the splenic pedicle exposed.
Courtesy, Lahey, F. H.: Surgical Practice of the Lahey Clinic, Philadelphia, W. B. Saunders Company, 1951.

from the abdominal wall with the spleen. One should remember in dealing with this type of spleen that a large part of the bleeding which occurs during avulsion of adhesions comes from lacerations of the spleen, which tears more easily than the parietal peritoneum, and also many if not

all of the veins in the adhesions do not empty into the vessels of the abdominal wall or diaphragm but course around the spleen's surface towards the pedicle.

At times, in patients who are bad risks and in questionable operative condition, with inadequate blood bank facilities available, ligation of the splenic artery near its origin from the celiac axis is all that can be safely done. Except in patients with a ruptured spleen or in a critical condition, time is not as important, however, as to have a dry field.

With few exceptions, an adequate amount of blood should be available during the operative procedure, though in certain conditions such as congenital hemolytic anemia, it is advisable that the transfusion be delayed until the pedicle has been ligated in order to prevent hemolytic crises from occurring.

Lastly, perhaps in regard to the actual technic of splenectomy, particularly in cases of congenital hemolytic icterus or primary thrombocytopenic purpura, one should be especially careful not to

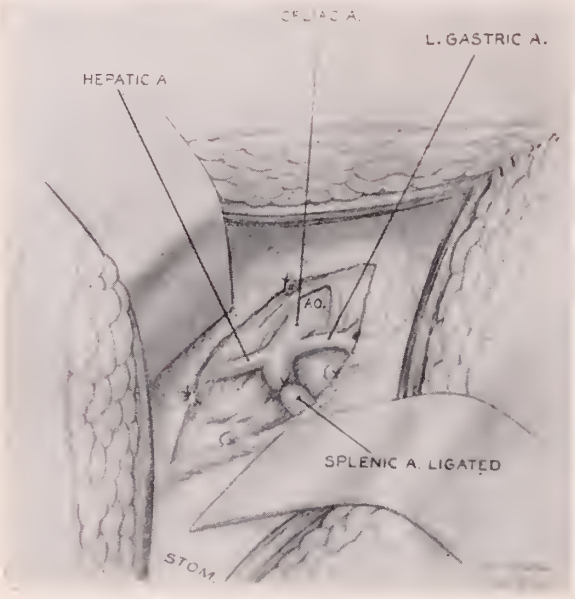


Fig. 3.—The stomach has been displaced downward; the gastrophepatic omentum has been incised and the celiac axis exposed.

Courtesy, Lahey, F. H.: Surgical Practice of the Lahey Clinic, Philadelphia, W. B. Saunders Company, 1951.

handle the spleen roughly. Seeding peritoneal implants by rough handling and tearing of the splenic capsule during the operation has been known to occur. These may grow and give a disappointing result.

Accessory Spleens

The end result of splenectomy, particularly for congenital hemolytic anemia or primary thrombocytopenic purpura, is influenced by whether or not accessory spleens which may be present are found and removed. This factor was suggested in 1928, and subsequent observations, particularly of the accessory spleen found in recurrences after splenectomy, have aided in establishing this conclusion.

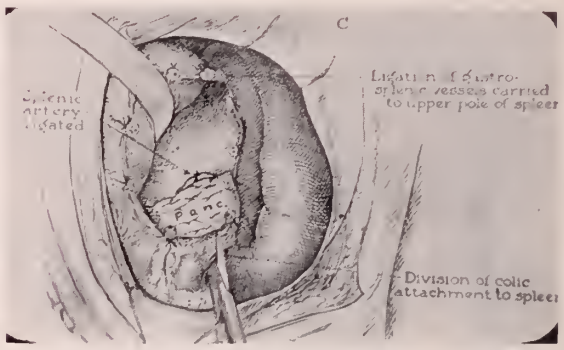


Fig. 4. — The gastrocolic omentum has been detached and the lesser peritoneal cavity widely opened. The stomach is reflected anteriorly and toward the right exposing the pancreas which can be seen through the floor of the lesser peritoneal cavity.

Courtesy, Cole, W. H. (Editor): Operative Technic in General Surgery, New York, Appleton-Century-Crofts, Inc., 1949, p. 686.

In a recent review based on 174 consecutive splenectomies and 4 abdominal explorations, Curtis and Movitz reported accessory spleens in 31.4 per cent of their cases. In these 56 patients 131 accessory spleens were found, with the number per patient varying from 1 to 10. Half of the patients presented only 1 accessory spleen. The percentage of instances was highest in the first decade and appeared to decrease with advancing age. This decrease was presumed to be due to a gradual involution and atrophy. In the 56 patients in their series in whom the accessory spleens were found, they were located in the following areas:

Location	Per Cent
Hilar	54.2
Splenic pedicle	25.1
Omentum	12.2
Retroperitoneal region surrounding the tail of the pancreas	6.1
Splencolic ligamentary attachments	1.5
Mesentery of large and small intestines	0.75
In female, left adnexa	0.15
	100.00

In 85.7 per cent of the patients the accessory spleens were found but in a single location. In no instance were they found in more than two locations in the same patient. If accessory spleens

Fig. 5.—The fingers are displacing the spleen medially and the parietal peritoneum is being incised.

Courtesy, Bancroft, F. W., and Wade, P. A. (Editors): Surgery of the Spleen in Surgical Treatment of the Abdomen, Philadelphia, J. B. Lippincott Company.

are left behind at the time of splenectomy, they can cause a recurrence of the primary splenic disease. In all cases, particularly in thrombocytopenic purpura and congenital hemolytic anemia, the surgeon should diligently look for and remove these accessory spleens.

In conclusion, in my opinion no surgeon should perform a splenectomy except in the case of a ruptured spleen without the wise judgment of the internist and the laboratory specialist.

References

Coller, F. A.; Blain, A., III, and Andrews, G.: Indications for and the Results of Splenectomy. Publication number 86, American Lecture Series, monograph in American Lectures in Surgery, edited by Michael E. DeBakey and R. Glen Spurling, Springfield, Ill., Charles C. Thomas, 1950.

Curtis, G. M., and Movitz, D.: Surgical Significance of Accessory Spleen, Ann. Surg. 123:276-298 (Feb.) 1946.

Hall, D. P.: The Spleen, a Few Surgical Aspects, Am. Surgeon 17:376-390 (May) 1951.

Lahey, F. H.: Technic of Splenectomy, S. Clin. North America 29:739-745 (June) 1949.

Lahey, F. H., and Norcros, J. W.: Splenectomy—When Is It Indicated? in Surgical Practice of the Lahey Clinic, W. B. Saunders Company, 1951, pp. 533-545; also, Ann. Surg. 128: 363-378 (Sept.) 1948.

Thorek, M.: Surgery of the Spleen, Modern Surgical Technic, in Surgery of the Breast, Surgery of the Abdomen, Philadelphia, J. B. Lippincott Company, 1949, vol. 3, pp. 2434-2472.

Walkling, A. A.: Spleen and Splenectomy, S. Clin. North America 31:1793-1800 (Dec.) 1951.

The Medical Center Clinic.

Pathology of Hypersplenism

V. Marklin Johnson, M.D.
West Palm Beach

Since removal of the spleen is usually attended by dramatic clinical improvement and a striking restoration of the blood picture to normal or near normal in a variety of conditions which exhibit a diminution of one or more of the formed blood elements, these conditions have been termed varieties of hypersplenism. The term implies an abnormal increase in splenic function. At the present time there is no general agreement as regards the pathogenesis of this increased function in the conditions termed idiopathic or essential thrombocytopenic purpura, splenic neutropenia and splenic pancytopenia. There is some agreement in respect to congenital hemolytic anemia. Attempts to correlate the morphologic pattern found in the spleens removed in cases of this disease with the pre-existing hematologic picture have also proved disappointing.

Doan[1-4] and his co-workers have for years clung doggedly to the theory of hypersequestration by the spleen of the deficient blood element or elements, while Dameshek[5,6] and his associates have championed a humoral hypothesis with the spleen elaborating a substance which inhibits the proper maturation and or release from the marrow of the deficient blood elements. Both groups have brought forth convincing evidence from their own laboratories, but attempts by others to reproduce their results have often been disappointing. Recently Wintrobe,[7] after a series of experiments on mice, expressed doubt as to the existence of any fully convincing evidence in support of either

Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 29, 1952.

the concept of cell destruction or of inhibition of cell production and/or delivery in the marrow.

The Normal Spleen

A review of the functions of the normal spleen seems pertinent at this point. Briefly these are: a reservoir for blood, an organ of erythrostasis, a lymphoid organ for production of lymphocytes and immune bodies; an organ participating in protein metabolism, a reticuloendothelial organ concerned with phagocytosis, production of monocytes, destruction of erythrocytes and formation of bilirubin, perhaps important in fat and protein metabolism, and a potential blood-forming organ. It probably exerts a control over the emission, enucleation and thickness of the red blood cells. Dameshek[8] stated that it probably controls the emission of granulocytes and may also control the formation of platelets from megakaryocytes. It is not an indispensable organ, but its removal is followed by leukocytosis, increased number of platelets, anemia or polycythemia, and such changes in the red blood cells as the appearance of target cells, Howell-Jolly bodies, and decreased osmotic fragility.

The normal weight of the spleen in the adult is approximately 150 Gm., although this will vary somewhat with its degree of engorgement. In the hypersplenic states its weight is always increased, although at times the increase may not be especially great. In essential thrombocytopenic purpura, as pointed out by Schwartz[9] and others, it seldom exceeds 300 Gm.; this is an important clinical finding, aiding in the differential diagnosis from other thrombocytopenic states. Its gross appearance, except in congenital hemolytic icterus, is not usually distinctive; in that condition, however, it is always firm and rubbery, usually having a smooth capsule and presenting an extremely dark red, almost black, cut surface, in which the splenic follicles are inconspicious. In the secondary hypersplenic states its appearance is usually characteristic of the primary disease causing the splenomegaly.

Logically one might expect to find the explanation of the increased splenic function by a study of its cellular components. Histologic studies were first concerned with its vascular supply and for years a controversy was waged as to whether it was an open or closed system. Today, as stated by Klemperer,[10] there is general agreement that it is open, but that under variable conditions the stomas of arterial terminations and of venous sinuses, as well as the grid of the reticulum mesh may become so small as to reduce it to a virtually closed one. The cellular components found in the spleen may be divided into those forming the capsule and trabeculae, those of the framework of the pulp, those of the blood vessels, and the free cells. Most attempts to explain splenic hyperfunction have centered about studies of the cells comprising the framework of the pulp and the free cells. Only in comparatively recent years has much attention been focused upon the lymphoid follicles and the perifollicular zone of adjacent cells.

The pulp is made up of a cytoplasmic reticulum and a fibrillar reticulum within which lie the cells and plasma. There is agreement that even in the adult spleen, the cytoplasmic reticulum retains its embryonal potentialities and may under different stimuli differentiate along four possible lines, namely, to form hematic, phagocytic, fibroblastic and endothelial elements. The free cells of the spleen are lymphocytes, monocytes, histiocytes (macrophages), and myeloid elements. The lymphocytes include small, intermediate and large forms, the small types predominating. The monocytes are identical with those of the peripheral blood and probably originate from the splenic reticulum. Among the phagocytic cells are erythrophagocytes and pigment cells.

The red pulp is normally the site of erythrostasis.

The white pulp is composed of a reticulum framework and reticuloendothelial and lymphoid cells. Two types of lymphoid follicles or malpighian corpuscles are present, namely, the primary follicles with pale center of lymphoblasts and few reticulum cells and small lymphocytes surrounded by a mantle zone of small lymphocytes and a marginal zone of large lymphocytes with intermingled red cells, and few mononuclear cells; the secondary follicles exhibit centers of small lymphocytes and are compact bodies lying in the reticulum.

Pathologic Changes

Thus in the pathologic study of hypersplenism one must search for changes in the structure of the vascular bed, in the reticulum mesh, its cellular components and contents, in the lymphoid follicles and their reticulum, and in the free cells of the spleen.

In congenital hemolytic anemia the hematologic changes and morphologic findings in the spleen seem to offer a plausible explanation of the pathogenesis of this condition. The congenitally defective red cell of this disease with its increased

osmotic fragility is found packed within the meshes of the red pulp. The primary defect is to be found within the spherocytic erythrocytes and not within the spleen. The abnormal cell is caught within the meshes of the reticulum of the pulp, producing a picture of great engorgement while the splenic sinuses are compressed and are relatively empty; trapped in this manner, the abnormally fragile erythrocytes are destroyed rapidly owing probably to the mechanism of stasis, as outlined by Crosby.[11] The lymphoid follicles are relatively inconspicuous, but usually show lymphocytic centers and an outer mantle of larger cells (lymphoblasts).

In regard to essential thrombocytopenic purpura, splenic neutropenia and splenic pancytopenia, the morphologic changes within the spleen are not sufficiently characteristic to enable a definitive diagnosis. In all three conditions, however, there is undoubtedly a quantitative increase in reticuloendothelial elements, both within the reticulum mesh and within the perifollicular zone of the follicles. The sinusoids are usually dilated, and there is active phagocytosis of the element or elements found deficient in the circulating blood. Platelets are difficult to identify in tissue sections and are not reported as seen by most observers.

Von Hamm and Awny,[12] in a study of 134 cases of hypersplenism, included supravital cytologic technics in their analysis. They concluded that neither the supravital nor the fixed smear from the spleen can lend itself successfully to the differential diagnosis between normal and hyperactive splenic conditions. They further concluded that the process of blood destruction in the hyperplastic spleen could not be explained by the process of phagocytosis alone although some degree of phagocytosis of the element or elements lacking in the peripheral blood was usually demonstrated. They pointed out the important facts that the clinical picture can be invoked by small accessory spleens which obviously may invoke only a small phagocytic function, that chemical investigations of their own seem to point to a humoral mechanism, and that such a mechanism may exert a hemolytic and cytologic effect upon stagnant blood elements.

Other investigators have directed special attention to hyperplasia of the cells lining the splenic sinuses, as well as to changes within the follicles termed the "inversion phenomenon," in which the central portions of the follicles are composed of deep-staining small lymphocytes while the reticuloendothelial cells surround such centers. Leffler,[13] in a study of 87 cases of various types of hypersplenism, noted prominent widened marginal zones composed of "lymphoblasts" in all but 1 case and found the same change but occasionally in a control series. He regarded this finding as a significant criterion in the pathologic diagnosis.

Summary

Considerable confusion still exists as to the pathogenesis and morphologic pathology of the hypersplenic states.

Congenital hemolytic anemia is primarily characterized by a congenitally abnormal erythrocyte; the spleen consistently exhibits a markedly engorged red pulp, the spaces of which are filled with spherocytes of this disease, and relatively empty sinuses. The lymphoid follicles are not distinctive, but may exhibit the "inversion phenomenon."

The morphologic findings in the spleen in essential thrombocytopenic purpura, splenic neutropenia, and splenic pancytopenia are not entirely characteristic and not sufficiently specific to enable a definitive diagnosis.

References

1. Doan, C. A., and Wright, C. S.: Primary Congenital and Secondary Acquired Splenic Panhematopenia, Blood 1:10-26 (Jan.) 1946.
2. Doan, C. A.; Curtis, G. M., and Wiseman, B. K.: Hemolytopoietic Equilibrium and Emergency Splenectomy, J. A. M. A. 105:1567-1574 (Nov. 16) 1935.
3. Wiseman, B. K.; Doan, C. A., and Wilson, S. J.: Present Status of Thrombocytopenic Purpura, with Special Reference to Diagnosis and Treatment, J. A. M. A. 115:8-13 (July 6) 1940.
4. Wiseman, B. K., and Doan, C. A.: Primary Splenic Neutropenia; Newly Recognized Syndrome, Closely Related to Congenital Hemolytic Icterus and Essential Thrombocytopenic Purpura, Ann. Int. Med. 16:1097-1117 (June) 1942.
5. Dameshek, W., and Miller, E. B.: Megakaryocytes in Idiopathic Thrombocytopenic Purpura, Form of Hypersplenism, Blood 1:27-51 (Jan.) 1946.
6. Stefanini, M., and others: Studies in Platelets, III. The Absence of Selective Sequestration and Destruction of Platelets by the Spleen in Idiopathic Thrombocytopenic Purpura, Blood 7:289-301 (March) 1952.
7. Palmer, J. G.; Kemp, I.; Cartwright, G. E., and Wintrobe, M. M.: Studies on the Effect of Splenectomy on the Total Leukocyte Count in the Albino Rat, Blood 6:3-15 (Jan.) 1951.
8. Dameshek, W., and Estrén, S.: The Spleen and Hypersplenism. A Reprint of an Exhibit Presented at the 100th Anniversary Convention of the American Medical Association, Atlantic City, June 1947. New York, Grune & Stratton, Inc., 1947.
9. Ehrlich, L., and Schwartz, S. O.: Splenomegaly in Thrombocytopenic Purpura, Am. J. M. Sc. 221:158-168 (Feb.) 1951.
10. Klemperer, Paul, in Downey, H.: Handbook of Hematology, vol. 3. New York, Paul B. Hoeber, Inc., 1938.
11. Crosby, W. H.: The Pathogenesis of Spherocytes and Leptocytes (Target Cells), Blood 7:261-274 (Feb.) 1952.
12. Von Hamm, E., and Awny, A. J.: Pathology of Hypersplenism, Am. J. Clin. Path. 18:313-322 (April) 1948.
13. Leffler, R. J.: The Spleen in Hypersplenism, Am. J. Path. 28:303-313 (March-April) 1952.

513 Harvey Building.

Discussions on Symposium

DR. STEVEN O. SCHWARTZ, summarizing: It was the plan, and it still is, that this should be an open discussion after my summary. For those of you who are bashful, it might be suggested that you send your questions up in written form, whereas those of you who are somewhat less bashful could perhaps ask your questions from the floor.

It is difficult to summarize so much material in two minutes and it may take me three. First, I think that we will all agree that most people have a spleen. That, I believe, is a statement we can make without too much fear of contradiction. There are exceptions, of course: these include patients who have had splenectomies and those with severe sickle cell anemia whose spleens have atrophied. There might even be an occasional congenital absence of the spleen.

Secondly, I think we will all agree that the spleen does something. Apparently, from the discussion we heard, that something is not always good. In fact, we may go so far as to say that it is bad. I think we will all agree that whatever this bad thing is that the spleen does is open to many interpretations. There is the Doan school, which is the hypersequestration school, and in that school apparently there are some dissenting voices. I imagine von Haam will be looking for a new job at the end of the academic term. There is the other school, which is the Eastern Seaboard school, and therefore a much better school, that of Dameshek. He believes that the spleen produces a hormone or a hormone-like substance which behaves primarily in an inhibitory fashion. And there is Wintrobe, way on the other side of the Mississippi, so far away that it probably does not matter much, who does not believe that either school is right. Maybe next year he will propound his own theory.

The fact of the matter is that there seem to be three mechanisms whereby the spleen can and most likely does manifest its abnormal behavior. One is the hormonal or humoral mechanism, which presumably acts at the level of cellular liberation from the marrow since in most cases of hypersplenism there is what we might describe as a maturation defect in the marrow. The cells are present, they are present in large numbers, they are present in mature forms, and at that point they apparently are stopped from getting into the peripheral blood stream. A second mechanism is the actual production of a substance in the spleen or more likely, as Dr. Trice suggested, in the entire reticuloendothelial system, which acts in a destructive fashion in the peripheral blood stream. And finally there is, according to the theory of Doan, a sequestration of cells in the spleen itself

It is interesting that in all instances of hypersplenism there is enlargement of the spleen. In idiopathic thrombocytopenic purpura this enlargement is minimal, as both Dr. Burtner and Dr. Johnson have already mentioned. In these instances, the enlargement of the spleen is usually of a magnitude less than 100 per cent; in other words, the spleen is usually less than 300 Gm. in size, and we are wont to question the diagnosis of idiopathic thrombocytopenic purpura in all instances in which the spleen is demonstrably enlarged by palpation. This degree of enlargement, with the spleen under 250 or 300 Gm., is not demonstrable on clinical examination except in the rare case to which Dr. Dell referred. Spleens of this size would of course be demonstrably enlarged by the x-ray technic already described.

In all other instances of hypersplenism, however, the spleen is demonstrably enlarged to palpation and, if I may beg your indulgence, sir, I believe that a good clinician should be able to feel spleens which are over 300 to 350 Gm. except in the rare patient who is tremendously obese. These spleens are almost always much larger than the 300 Gm. alluded to, and therefore demonstration of the splenomegaly should not be too difficult.

I do not think that we can overemphasize the fact that there are no ironclad rules for making a diagnosis of hypersplenism, nor can we underestimate the importance of this diagnosis in both prognosis and therapy.

Let us take the papers of the essayists one by one, as I made notes on them, and by the way these are not points either of disagreement or addition, but rather points which I think bear additional emphasis. Beginning with Dr. Kaplan's paper on hemolytic anemias, it is most important, I think, to remember that in congenital hemolytic anemia or jaundice the role of the spleen is apparently a double one. The spleen undoubtedly produces some of the hemolytic substance which plays a role—a role which I think Dr. Kaplan tended to

de-emphasize—and the spleen's removal is further curative because it is in the sinusoids of the spleen where the red blood cells are apparently destroyed most rapidly due to stasis. With this organ of stasis removed, the cell survival is just sufficiently increased to enable the patient to recover balance between blood destruction and regeneration.

In the acquired hemolytic anemias, the role of the spleen is much less important, and even in those patients in whom there is a demonstrable splenomegaly, only about one third are cured by splenectomy, about one third are benefited by splenectomy, and one third are not made any better. So in those cases the prognosis is doubtful and the risk of splenectomy consequently much greater. In all these patients, however, every effort should be made to determine the cause if possible, since the cause may lie entirely outside of the spleen in the field of chemicals, drugs, allergies, or tumors.

In the discussion of thrombocytopenic purpura by Dr. Burtner, one most important point I think was not sufficiently stressed and that is the fact that thrombocytopenia is a very serious disease which carries an over-all mortality of somewhere around 20 per cent. Any disease in which 1 patient out of 5 dies cannot be dismissed as easily as most textbooks dismiss this one. In most textbooks one reads that diagnosis is made by steps one, two, three and four, the patient is splenectomized, and one assumes that thereby the patient is cured. That is not the entire story. Unfortunately many patients are splenectomized and are not cured. I am sure that that experience is shared by Dr. Burtner. An even more distressing feature to us has been the fact that we are unable, even in retrospect, to demonstrate any difference in the patient who is cured and the one who is not cured. Whether some of these more recent studies with antibodies Dr. Burtner mentioned will cast light on the subject remains to be seen.

I was greatly interested in the particular case report which was given. The patient apparently started off with a simple allergic thrombocytopenic purpura and should have recovered after the offending agent was removed; yet the chain of events continued until the patient not only had a thrombocytopenia but a hemolytic anemia, a leukopenia and, interestingly, a splenomegaly. I wonder if later in your discussion, Dr. Burtner, you might tell us if there was anything found in that spleen, although I imagine the answer is negative since it probably would have been mentioned if there had been.

It cannot be overemphasized that the diagnosis of thrombocytopenic purpura is simply the diagnosis of a symptom, and here again every effort must be made to find the precise underlying disease in accordance with the suggested subdivisions which Dr. Burtner offered.

I do think that Dr. Trice was at a distinct disadvantage in his discussion since it is most difficult to discuss the agranulocytoses or the neutropenias alone in this group of diseases for these usually occur in various combinations. His point about the importance of careful critical clinical evaluation of the individual patient bears repetition. I think Dr. Trice was being most kind in avoiding any reference to Doan's adrenalin test. I think he was being gracious to me as a guest — perhaps more so than was really necessary. As you undoubtedly know, Doan proposed that one can prognosticate the results of a splenectomy from his adrenalin test. Many of us have been performing the adrenalin test, or at least did so long enough to have become discouraged by it. Since coming down here I have learned that a new sentence has been added to the way the test should be done, which I think is important even though it comes some 15 years after the introduction of the test, and that is that the adrenalin must be given in quantity sufficient to raise the patient's pulse. Perhaps we will go back to performing the test, raising the patient's pulse without raising our own, and will learn something new about the value of the test. It is difficult sometimes to belong or be classified as belonging to one camp or the other and yet not admit that one's pulse is raised by adrenalin.

Dr. Dell spoke about the importance of the differential diagnosis of masses in the left upper quadrant of the abdomen, and as he was discussing it, I remembered many of our cases in which, had we resorted to roentgen examination, we would not have fallen quite as flat on our faces as we did. Among masses or tumors which we somehow or other mistook for spleens have been cysts of the tail of the pancreas, cysts of the mesentery, lymphosarcoma of the stomach, retroperitoneal lymphosarcoma, hypernephroma, congenital cystic disease of the kidney, hairball of the stomach, and carcinomas of the splenic flexure. I plead guilty to all these errors of diagnosis and I am sure that most of us who see enough large masses in the left upper quadrant, unless we are meticulous in

evaluating the mass, will make similar mistakes. I think that the use of roentgen examination of the abdomen of patients in whom there is a reasonable doubt as to the nature of the mass, is a most valuable contribution.

To Dr. Morse's discussion of the question of splenectomy and the operative approach, I should like to add just two small points, if I may, which we have learned to practice in the postoperative management of our patients. I am sure that it was only the brevity of time which prevented Dr. Morse from discussing them. In the presulfonamide and the prepenicillin era our operative mortality with splenectomy was almost prohibitive, and that of course was aggravated by the fact that transfusions of blood were not nearly as easily available as they are today. But the main cause of death was atelectasis of the lower lobe of the left lung with a consequent pneumonia. So even before the era of sulfonamides and penicillin, we introduced oxygen therapy routinely in the postoperative management of our patients and thereby reduced the mortality appreciably. Subsequently, with sulfonamide drugs available, they became part of our postoperative routine, and now we have substituted antibiotics for them. This has made a tremendous difference in the survival rate of our patients after splenectomy so that we approach the operation with relatively little trepidation even in the critically ill and highly complicated cases.

I think I should be most presumptious to comment on your remarks, Dr. Johnson.

If there are any questions, I am sure this excellent panel, composed of hematologists, a surgeon, a pathologist and a roentgenologist will tackle anything you can throw at it. Are there any questions?

The first question submitted is: What about the necessity of splenectomy in thrombocytopenia occurring in infectious mononucleosis?

There are cases reported in which splenectomy has been performed in patients with infectious mononucleosis due to thrombocytopenia. We have had 3 cases now in which thrombocytopenia was due to infectious mononucleosis, and we assumed that it was due to hypersplenism. In 1 case we worried for about three weeks before the platelets started to return to normal. In the other 2 cases we had much less time to wait. I think that by and large, unless the hemorrhages are dangerous, or unless the patient happens to be so old that cerebral vascular accidents are likely, I should manage a patient like that conservatively. By conservatively I mean possibly with ACTH although I am not sure that I would use it, possibly with blood transfusions although we are getting more and more conservative in our use of blood transfusions. We are more and more aware of the unfortunate complication of serum hepatitis following blood transfusion, and so unless we have to use blood we avoid it. But I think in any case, unless extremely severe or unless the hemorrhage were threatening life, I should certainly want the patient managed conservatively.

DR. GRETCHEN V. SQUIRES, Pensacola: In a familial thrombocytopenic purpura case (patient aged 6) with failure of response to splenectomy, should a bone marrow study which fails to reveal normal megakaryocytes preclude a further operation for accessory spleens?

DR. SCHWARTZ: Dr. Burtner, would you care to answer that, sir?

DR. BURTNER: I do not know whether I can answer the question from the information given. Dr. Schwartz, perhaps we can call on you for your comments. The patient is 6 years old, has a familial thrombocytopenic purpura and has not improved after splenectomy. The bone marrow fails to reveal normal megakaryocytes. Evidently, if this diagnosis is correct and the patient does have familial, idiopathic thrombocytopenic purpura, he either falls into the group that, for reasons as yet unknown, is not completely cured after removal of all the splenic tissue, or there may still be some splenic tissue remaining. This poses a difficult problem and one with which we should like to have our x-ray friends help us. Is there or is there not any accessory splenic tissue there? If we did have a technic whereby, with the injection of thorotrast, or preferably some substance that would not cause marrow depression, we could learn when accessory splenic tissue is present, we would be able to decide the important question of whether or not reoperation is indicated in a given patient. My first reaction is of course to be certain that we have the correct diagnosis in this case. Has the Coombs test been performed, and has a work-up been carried out for a possible associated hemolytic anemia? Have we also ruled out the allergic form of thrombocytopenic purpura, and could it be possible that there is an underlying blood disorder such as one of the lymphomas or leukemias? But if we do accept the fact that we are dealing here with idiopathic thrombocytopenic purpura, I think we have an exceedingly difficult

decision to make. Certainly we cannot, as Dr. Schwartz has pointed out, expect 100 per cent cures — far from it, perhaps 60 to 85 per cent of patients are benefited. I am going to pass this question back to you, Dr. Schwartz, and ask for your further comments.

Dr. Schwartz: May I ask whoever asked this question, what results were obtained in other members of the family? I presume that since the diagnosis of familial thrombocytopenic purpura was made in this patient, other members of the family may have had splenectomies.

Dr. Squires: This child had one sister who died of idiopathic thrombocytopenic purpura despite splenectomy.

Dr. Schwartz: Had no response?

Dr. Squires: Dr. Morse was the attending surgeon.

Dr. Morse: I did not operate on the patient.

Dr. Squires: You would have if the bone marrow had not shown an absence of megakaryocytes.

Dr. Schwartz: This is a most interesting case from the standpoint of two members of a family having thrombocytopenia. I think we should simply stick to the question, and that is "Should a marrow study which fails to reveal normal megakaryocytes preclude a further operation for accessory spleens?" By normal megakaryocytes you are speaking here quantitatively?

Dr. Squires: Both quantitatively and qualitatively. There was one abnormal megakaryocyte in four slides.

Dr. Schwartz: That certainly is quantitative. I am most skeptical about the ability of all of us west of the Alleghenies to know the difference between normal and abnormal megakaryocytes. You see, hematology is definitely sectional. The question of differentiating between normal and abnormal megakaryocytes is problematical, and it is only my reluctance to tell tales out of school that prevents me from telling a story about someone who claims that he can tell them apart. Certainly in this patient there would be no point in looking for accessory spleens. I think the defect here is in the megakaryocytes or the megakaryocyte-forming tissues of the marrow. I might be tempted to try some thorotrast in a patient such as this since the life expectancy is probably limited and since the complications which we fear from thorotrast are minimal, but from the evidence you give us, I doubt if re-exploration would help.

The only patients in whom we have ever seen re-exploration for accessory spleens of any value have been patients who have been cured of their disease and have remained well for a matter of months or years and then had a recurrence. We have re-explored a great number of patients who had thrombocytopenia and did not respond to splenectomy. We re-explored them because the obvious assumption was that accessory spleens were left behind. Some of them were re-explored and unfortunately a number were autopsied, but even meticulous search for accessory spleens was unrewarding.

Dr. Egbert V. Anderson, Pensacola: Dr. Schwartz, what is the opinion of the panel as to the efficacy of ACTH and/or cortisone in this particular case?

Dr. Schwartz: Dr. Burtner, would you care to answer this one?

Dr. Burtner: I should be glad to make a brief comment. Dr. Muriel Meyers, working in Dr. Cyrus Sturgis' laboratory, last week at the meeting in Cleveland, reported their experience with the use of ACTH in idiopathic thrombocytopenic purpura. She reported remissions for as long as 15 months, and there have been other similar remissions recorded. Remissions of this length, however, are apparently most unusual. In her paper, reporting some 25 cases I believe it was, I think the average length of remission was something like two, three or four weeks after discontinuing ACTH. I think, however, that from paper to paper, or one laboratory to another, one will get a different viewpoint towards the use of ACTH and cortisone, both in idiopathic thrombocytopenic purpura and in hemolytic anemia. We are all, however, probably going to come to the decision that ACTH and cortisone are not permanently curative, or at least we do not know of any patients so far who have been permanently cured of idiopathic thrombocytopenic purpura by them after long follow-up observation.

I think the administration of ACTH and cortisone in this case might be valuable in one respect. If there were a good response from such administration, it might possibly argue for the presence of some accessory splenic tissue, but it would not be at all conclusive on this point. One point against such a trial is of course the age of the child in relation to undesirable secondary effects that might be produced after a time by the hormone. Dr. Schwartz, would you comment further?

Dr. Schwartz: I have no further comment. sir. Does that answer the question?

DR. ANDERSON: I should like to ask just one more detail. How long does it take to get these remissions? I understand there is a delay of quite some time before these remissions appear.

DR. SCHWARTZ: Are you referring to after the administration of ACTH?

DR. ANDERSON: From the time it is started.

DR. SCHWARTZ: Do you care to answer that, Dr. Burtner?

DR. BURTNER: You answer it.

DR. SCHWARTZ: In our experience, if there is to be a remission, it occurs in a week or two. We prefer intravenous ACTH because we can give minimal amounts for maximum results and minimal side reactions. It is our feeling that unless there is response within three weeks, there will be none. That assumes that one is giving adequate doses. I think it is most important to emphasize that both cortisone and ACTH, in both hemolytic anemias and thrombocytopenic purpuras, have to be given in sufficiently large doses to produce these effects. We have seen failures, especially when we were first experimenting with depot ACTH and failed to get results. Subsequently, when we gave the drug in a form in which it was absorbed rapidly or when we changed to the intravenous route, we did get results.

The next question is: What percentage of hyposplenism occurs in relation to hypersplenism? I like all these men; I do not know to which one I should give this question. Dr. Trice, would you like to answer it? I am really not picking on you.

DR. TRICE: I do not know why I am singled out. I would be glad for you to answer that.

DR. SCHWARTZ: I can answer it very simply. I do not know. Hyposplenism we certainly have a right to postulate in those patients we have already mentioned who had no spleens, and those are the patients who had extirpation, had atrophy as in sickle cell anemia, and except for the changes which were described, after the removal of the spleen, by Dr. Johnson, there are no other symptoms. Is there any particular point that the gentleman who sent this up wanted to make? Perhaps we are missing the point of the question.

QUESTIONER: It struck me that from the vast amount of information presented in the papers discussed this afternoon, it appears that for practically everything we have in pathology we have the opposite. Also, in the endocrines we have the opposite. That is why I was moved to ask the question because I thought your experience would give at least some information in regard to the opposite condition, hyposplenism.

DR. SCHWARTZ: In answer to that I think I can go back to the points Dr. Johnson made in reference to what happens in the peripheral blood when the spleen is removed. Now that is not strictly hyposplenism in the sense in which we think of let us say hypothyroidism, because this is usually following the extirpation of an abnormal organ. Since, however, the changes that take place also occur after the removal of a normal spleen, we must assume that the targeting, the leukocytosis, the lymphocytosis, and the inadequate removal of nuclei as manifested by Howell-Jolly bodies are probably manifestations, at least gross manifestations, of hyposplenism. My guess is that since the spleen seems to be as important an organ as it is, there are other changes which must take place in the nonmorphologic elements of the blood. But most of these in time apparently correct themselves, and our explanation is that other reticuloendothelial tissues take over the normal functions of the spleen without actually developing into little spleens or spleniculi.

Another request is: Discuss the mechanism of the hemolytic crisis in chronic familial hemolytic anemia. Dr. Kaplan, would you like to take this?

DR. KAPLAN: The mechanism of crisis in familial hemolytic icterus is twofold: The original description of the crisis was that of a precipitous fall in red blood cell count and hemoglobin, leukocytosis, great increase in the nucleated red blood cells in the peripheral blood and a differential count which approached a leukemoid type. In conjunction with this, there was advocated the idea of a superhyperplasia of the marrow in an attempt to compensate for a superimposed peripheral destruction. More recently, however, by Dr. Owren and by others in different parts of the United States it has been advocated that the crisis of familial hemolytic icterus is not a hyperplastic crisis at all, but that initially as a result of infection or other provocative causes, there is a suppression of red cell formation in the marrow, and rather than being called hyperplastic crisis, this has been called aplastic crisis. These hematologists have shown excellent marrow preparations in which a full marrow becomes an empty one in so far as the red cell elements are concerned. You will recall the fact that in congenital hemolytic icterus the red cell survival time is considerably less than normal, that is considerably less than 100 days. Thus in a period of four or five days with abrupt cessation of red cell output from the marrow, these cells which survive only a short period of time will precipitously die off and the

red cell count and hemoglobin precipitously fall. So the concept of the mechanism of crisis in hemolytic anemia now has to be somewhat tempered with the idea that perhaps most of the crises that occur are observed five days or more after they initially appear, at a time when the marrow is then compensating for the aplastic situation which originally presented itself, and that part of what have been referred to as hyperplastic crises are really aplastic situations with initial suppression of red blood cell formation. There have been opportunities, in families of congenital hemolytic icterus where one child will develop an infection and it would be anticipated that others would incur the same infection, for a study of the marrow and peripheral blood of the sibling, and this idea of aplastic crisis has been confirmed. Sometimes the crisis is precipitated by an attack of cholecystitis, a frequent cause. Cholelithiasis, as you know, is extremely common in congenital hemolytic icterus since there is an overwhelming passage of bile through the biliary tract. Not infrequently a nidus forms and pigment stones occur, and an attack of biliary obstruction from stone or infection from stasis may provoke an attack of hemolytic crisis.

Dr. Schwartz: This question has been submitted: Would you expect any benefit from cortisone or ACTH in pancytopenia due to myelophthisis? Would you care to answer that, Dr. Trice?

Dr. Trice: The appearance of depression peripherally of the formed elements of the blood in the myelophthisic anemias or invasion anemias produced by invasion of the bone marrow has been of course investigated under the name of aplastic anemia. Really it is hypoplasia of all the formed elements of course, and its response to cortisone and ACTH has been extremely disappointing, even in marrow sections followed serially over a period of months. The expectation of any benefit from cortisone or ACTH in this type of anemia is, I am sure, beyond reason. It is too much to expect even of the miracle drugs.

Dr. Schwartz: How accurate are megakaryocyte counts on bone marrow? Dr. Burtner, would you care to answer this question?

Dr. Burtner: I am a poor choice to answer the question because I do not follow the practice of making megakaryocyte counts on bone marrow samples. I know that certain laboratories do make such counts, especially for research purposes. In my opinion a good look at a marrow smear, provided it has been made on a cover slip, gives an excellent idea (1) as to the number of megakaryocytes present, as estimated by looking through the low power objective, and (2) the quality of the megakaryocytes, studied under a higher power. In a classical case of idiopathic thrombocytopenic purpura (ITP) there is usually a considerable increase in megakaryocytes and megakaryoblasts together with evidence of immaturity of the nucleus, basophilia of the cytoplasm and poor platelet formation. It is also true, however, and a point of some confusion, that in allergic thrombocytopenic purpura (ATP), developing as a result of sensitivity to such drugs as salicylates or sulfonamides, there may be much the same picture of increased numbers of megakaryocytes with the same abnormalities of them; hence we cannot use the bone marrow as a point of differentiation between these two related disorders. I think we should not place too much emphasis on the absolute number of megakaryocytes, since we know they can be increased in a number of other conditions in which the bone marrow is stimulated or irritated.

Dr. Schwartz: The next request is: Please discuss the method you use in palpation of the spleen. Is there a willing subject in the audience? I should be happy to demonstrate on her. I think in palpating for the spleen, it is most important to assume a priori that the spleen is enlarged and then make every possible effort to prove that it is enlarged. Most of the spleens which are missed on palpation are the huge spleens which fill the left half of the abdomen. The examiner puts his hand on the abdomen, and there is no splenic edge where he expects to find it; so he dismisses the spleen. We recommend that one palpate the abdomen with as much thoroughness as one examines the chest. That is unfortunately not too often done. We also find that placing the patient on his right side with the legs drawn up, thereby relaxing the abdominal wall, helps greatly in finding spleens which otherwise are somewhat more difficult to feel. But, above all, the important thing is to assume that the patient has splenomegaly, which of course in our field is a fairly safe bet.

One point I should like to make in this connection is that we do not consider palpable spleens normal, even though every once in a while we do find, especially in younger persons, a splenomegaly which we are unable to explain. Certainly every patient with a splenomegaly is deserving of a thorough evaluation. Are there any other questions?

Dr. James N. Patterson, Tampa: Dr. Schwartz, about a year ago, Dr. Doan of Colum-

bus, who was mentioned earlier in the discussion, gave a course in Jacksonville in which he advocated the use of thorotrast in the search for accessory spleens. I wonder if Dr. Dell would tell us why he is so afraid of thorotrast.

DR. SCHWARTZ: Dr. Dell, sir.

DR. DELL: Dr. Patterson, I have had no experience with thorotrast. I would have to be guided entirely by the opinion of Dr. Coe, who has had a world of experience with it. He thought that as a general rule the diagnostic yield did not justify the risk. As Dr. Schwartz brought out, in the occasional case if it is extremely important to find the small accessory spleen, then it would probably be wise to take that risk, the risk being entirely, as far as I can gather from Dr. Coe, the extravenous extravasation of the thorotrast into the tissues. Of course you know the experiments on the ventricles of dogs and the ventricles of monkeys that have been carried out. Just as a defense about palpating the spleen versus the roentgen ray examinations, I should like to say to Dr. Schwartz that this is what makes horse races and that I believe probably the ability of the clinician to palpate spleens also has a geographic distribution.

DR. SCHWARTZ: I should probably have been a most disappointed man if there had not been at least a little controversy. Are there any other questions? If not, I should like to congratulate Dr. Patterson on bringing together so distinguished a group of participants in this symposium and to thank him for inviting me. I hope that I have adequately fulfilled my role of a moderator. Thank you.

DR. HERPEL: Thank you very much, Dr. Schwartz, and the members of this Association who have participated in this most interesting discussion. This departure from the usual procedure in setting up these scientific assemblies was done with some doubts. The attendance at this meeting and the fact that so many have stayed throughout the entire symposium furnish good evidence that there is a genuine interest in the production of such a symposium. I think I can assure you that the experiment probably will be repeated.

ABSTRACTS OF MEDICAL ARTICLES

Paralysis Caused by Penicillin Injection; Mechanism of Complication — A Warning. By I. M. Tarlov, M.D., I. Perlmutter, M.D., and A. J. Berman, M.D. J. Neuropath. & Exper. Neurol. 10:158-176 (April) 1951.

Results of experiments are reported which clarify the mechanism that produces severe peripheral neuritis as an immediate complication of the intramuscular injection of penicillin. These experimental observations offer an explanation of the mechanism by which almost complete sciatic paralysis immediately followed the intragluteal injection of penicillin in a patient whose case history is presented.

This extensive investigation established that the intense and persistent neuritis, accompanied by pronounced interruption of nerve function, is attributable to the introduction of the material directly into the parenchyma of the nerve. The resultant inflammatory reactions were much more intense with the oily than with the soluble penicillin. Streptomycin injections produced similar reactions. The nerve sheaths appeared strongly to resist the inflammatory reactions and thus to protect the nerve fibers when penicillin was injected around the nerve or into its epineurial sheath. Also, hemorrhage into or around the sciatic nerve did not cause the neuritis.

Delayed impairment of nerve function, occurring after eight to seventeen days in some cases, offered the experimental counterpart of the similarly delayed onset of symptoms referable to neuritis in human cases, in which the neuritis was probably due to progressive inflammatory and fibrotic changes.

When administering penicillin or any other form of intramuscular therapy, the authors warn, one should make the injections remote from the site of any of the large nerve trunks. The chosen site for intragluteal injections should be the upper outer quadrant. In view of the danger of pulmonary embolism, it is important also to guard against the intravenous injection of the oily suspension of penicillin. Repeated aspiration of the material should be attempted during the injection.

The Treatment of Larva Migrans with Stibanose, A Preliminary Report. By J. Frank Wilson, M.D. South. M. J. 45:127-130 (Feb.) 1952.

In this preliminary report on the use of stibanose in the treatment of larva migrans or creeping eruption, Dr. Wilson discusses the incidence, etiology and various methods of treatment of this skin disorder, which for some years has given cause for growing concern in the coastal regions of the Southeastern United States. He notes that in Florida alone in 1950, over 7,000 cases were reported, with probably twice that number unreported.

In his series of 75 cases, treatment with stibanose effected complete cure in 30 per cent, was highly effective in 66 per cent, making the patient comfortable in approximately twenty-four hours, and was ineffective in 4 per cent. No unfavorable reactions occurred.

In view of the prevalence of larva migrans and the need for improved therapy, Dr. Wilson concludes that stibanose warrants extensive clinical trial as the treatment of choice, supplemented by topical application of ethyl acetate collodion, and freezing of individual lesions when necessary.

Histological Studies of Carcinoma of the Prostate Treated by Estrogen. By Philipp R. Rezek (by Invitation), Milton M. Coplan, Frank M. Woods and Perry D. Melvin. J. Urol. 66:379-389 (Sept.) 1951.

Studying hundreds of prostates surgically removed or obtained from autopsies for the past six to eight years, the authors noticed so-called squamous cell metaplasia (the transformation of columnar or cuboidal epithelium into squamous epithelium) more frequently than expected, no matter whether these glands showed benign hypertrophy, with or without inflammatory changes, prostatic infarcts, calculi, or carcinoma. In a number of these cases, the patient had received stilbesterol for one reason or another. This observation suggested studies on the histologic influence of stilbesterol on carcinoma of the prostate and its metastases.

Four cases are presented, representing similar response to estrogen in different types of cases. In the first case, clinically misdiagnosed as carcinoma, the patient received stilbesterol and was then subjected to operation. The second case was one of carcinoma, in which estrogen therapy was followed by surgery. In both of these cases the connection between metaplasia and estrogen administration, while not conclusive, appeared highly probable.

Carcinoma was present in the third case, in which orchiectomy was performed; stilbesterol therapy was continued for years, repeated biopsies were obtained and transurethral resection was performed six times. Study of the numerous biopsies showed how the pattern of the carcinoma changed under the influence of the different therapeutic procedures. It appeared highly probable that under the influence of stilbesterol the carcinoma changed its aspect completely, inasmuch as the adenocarcinoma was converted into a poorly differentiated squamous cell carcinoma.

The fourth case, one of carcinoma with metastases treated by estrogen therapy, terminated fatally, and autopsy was performed. The particular importance of this case lies in the evidence it offered that estrogen not only changes the pattern of the primary tumor but also produces metaplasia in its bone metastases, apart from well known fibrosis and osteoplasia, an anomaly believed not previously described in the literature.

It is concluded that the administration of estrogen seems to induce the changes described, which may explain its favorable effects on primary carcinoma of the prostate and its bone metastases.

The Surgical Significance of the Cardiosplanchnic Reflex. By Donald W. Smith, M.D., and Matthew A. Larkin, M.D. South. M. J. 44:399-407 (May) 1951.

The authors present a diagnostic aid in the differentiation between cardiac and abdominal visceral lesions in those cases in which the region of pain manifestation is misleading.

Seven cases are presented illustrating severe abdominal pain in cardiac lesions and severe precordial pain in abdominal visceral lesions. The mechanism of transfer is described as the cardiosplanchnic reflex, through an anatomic overlap of the lower cardiac nerves and the upper splanchnic nerves at the fourth and fifth dorsal segments.

A stellate block, successfully performed, will relieve or alter pain of cardiac origin regardless of where it occurs, but will not alter chest pain of abdominal or splanchnic origin. A splanchnic block, on the other hand, will promptly relieve severe pain of upper abdominal visceral origin even though it is manifest in the chest.

Methods of stellate and splanchnic block are described and illustrated which are relatively safe, and technically simple to perform.

FLORIDA MEDICAL ASSOCIATION

OFFICERS AND COMMITTEES

OFFICERS

ROBERT B. MCIVER, M.D., President.....*Jacksonville*
FREDERICK K. HERPEL, M.D., Pres.-elect..*West Palm Beach*
FRANCIS H. LANGLEY, M.D., 1st Vice Pres...*St. Petersburg*
ERASMUS B. HARDEE, M.D., 2nd Vice Pres.....*Vero Beach*
H. QUILLIAN JONES, M.D., 3rd Vice Pres.....*Fort Myers*
SAMUEL M. DAY, M.D., Sec'y-Treas.....*Jacksonville*
SHALER RICHARDSON, M.D., Editor.....*Jacksonville*

MANAGING DIRECTOR

STEWART G. THOMPSON, D.P.H.....*Jacksonville*
ERNEST R. GIBSON, Assistant.....*Jacksonville*

BOARD OF GOVERNORS*

ROBERT B. MCIVER, M.D., Chm...(Ex Officio).*Jacksonville*
JAMES L. BORLAND, M.D...AL-53.....*Jacksonville*
DUNCAN T. MCEWAN, M.D...B-53.....*Orlando*
JAMES H. POUND, M.D...A-54.....*Tallahassee*
NORVAL M. MARR, M.D...C-55.....*St. Petersburg*
JOHN D. MILTON, M.D...D-56.....*Miami*
HERBERT E. WHITE, M.D...PP-53.....*St. Augustine*
DAVID R. MURPHEY, JR., M.D...PP-54.....*Tampa*
FREDERICK K. HERPEL, M.D. (Ex Officio).*W. Palm Beach*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*
HERBERT L. BRYANS, M.D...S.B.H.-53.....*Pensacola*
STEWART G. THOMPSON, D.P.H. (Advisory)...*Jacksonville*

*SUB-COMMITTEES

1. Veterans Care
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
GEORGE M. STUBBS, M.D.....*Jacksonville*
DOUGLAS D. MARTIN, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

2. Advisory to National Foundation Infantile Paralysis
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
H. PHILLIP HAMPTON, M.D.....*Tampa*
ROBERT P. KEISER, M.D.....*Coral Gables*
RICHARD G. SKINNER, JR., M.D.....*Jacksonville*

3. Review of Fee Schedules
JOHN D. MILTON, M.D., Chm.....*Miami*
WOODROW B. ESTES, M.D.,.....*St. Petersburg*
FREDERICK H. BOWEN, M.D.....*Jacksonville*
ODIS G. KENDRICK, JR., M.D.....*Tallahassee*
JAMES B. GLANTON, M.D.....*Orlando*
FLOYD K. HURT, M.D.....*Jacksonville*
HERSCHEL G. COLE, M.D.....*Tampa*
A. FRANKLIN HARRISON, M.D.....*Madison*
JACK O. W. RASH, M.D.....*Miami*
KENNETH S. WHITMER, M.D.....*Miami*
ADELBERT F. SCHIRMER, M.D.....*Orlando*

1. Blue Shield
LEIGH F. ROBINSON, M.D., Chm.....*Fort Lauderdale*

SCIENTIFIC WORK

JAMES N. PATTERSON, M.D., Chm...AL-53.....*Tampa*
CAROL C. WEBB, M.D...A-53.....*Pensacola*
FREDERICK K. HERPEL, M.D...D-54.....*West Palm Beach*
JERE W. ANNIS, M.D...C-55.....*Lakeland*
RICHARD C. CUMMING, M.D...B-56.....*Ocala*

LEGISLATION AND PUBLIC POLICY

H. PHILLIP HAMPTON, M.D., Chm...B-53.....*Tampa*
WILLIAM M. ROWLETT, M.D...AL-53.....*Tampa*
DANIEL A. MCKINNON, M.D...A-53.....*Marianna*
ANGUS D. GRACE, M.D...C-55.....*Fort Myers*
DONALD W. SMITH, M.D...D-56.....*Miami*
ROBERT B. MCIVER, M.D. (Ex Officio).....*Jacksonville*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*

MEDICAL EDUCATION AND HOSPITALS*

JACK O. CLEVELAND, M.D., Chm...AL-53.....*Coral Gables*
JULIUS C. DAVIS, M.D...A-53.....*Quincy*
ELBERT MCLAURY, M.D...D-54.....*Hollywood*
S. CARNES HARVARD, M.D...C-55.....*Brooksville*
BENJAMIN F. DICKENS, M.D...B-56.....*Fernandina*

*SPECIAL ASSIGNMENT

1. Urge Gifts to American Medical Education Foundation

PUBLIC RELATIONS*

EUGENE B. MAXWELL, M.D., Chm...M.-53.....*Tampa*
LEIGH F. ROBINSON, M.D...D-53.....*Fort Lauderdale*
HOWARD V. WEEMS, SR., M.D...C-54.....*Sebring*
EUGENE G. PEEK, JR., M.D...B-55.....*Ocala*
HENRY L. SMITH, JR., M.D...A-56.....*Tallahassee*

*SPECIAL ASSIGNMENTS

1. Rural Educational Program
2. State Education Campaign

NECROLOGY

ALVIN L. STEBBINS, M.D., Chm...A-56.....*Pensacola*
HUGH WEST, M.D...AL-53.....*DeLand*
JOSEPH HALTON, M.D...C-53.....*Sarasota*
WALLACE H. MITCHELL, M.D...D-54.....*Key West*
JOSEPH J. LOWENTHAL, M.D...B-55.....*Jacksonville*

MEDICAL POSTGRADUATE COURSE

TURNER Z. CASON, M.D., Chm...B-55.....*Jacksonville*
ARTHUR J. BUTT, M.D...AL-53.....*Pensacola*
FRANZ H. STEWART, M.D...D-53.....*Miami*
J. BROWN FARRIOR, M.D...C-54.....*Tampa*
FRANCIS T. HOLLAND, M.D...A-56.....*Tallahassee*

CANCER CONTROL

FRAZIER J. PAYTON, M.D., Chm...D-54.....*Miami*
MILTON C. MALONEY, M.D...AL-53.....*Jacksonville*
ROBERT L. TOLLE, M.D...B-53.....*Orlando*
GEORGE W. MORSE, M.D...A-55.....*Pensacola*
WESLEY W. WILSON, M.D...C-56.....*Tampa*

MEDICAL ECONOMICS

REUBEN B. CHRISMAN, JR., M.D., Chm...AL-53....*Miami*
JOHN E. MAINES, JR., M.D...B-53.....*Gainesville*
HARRISON A. WALKER, M.D...D-54.....*Miami*
WILLIAM H. WALTERS, JR., M.D...C-55.....*Lacoochee*
WILLIAM C. ROBERTS, M.D...A-56.....*Panama City*

VENEREAL DISEASE CONTROL

MELVIN M. SIMMONS, M.D., Chm...C-55.....*Sarasota*
JOHN R. BROWNING, M.D...AL-53.....*Jacksonville*
JOHN C. MCSWEEN, JR., M.D...A-53.....*Pensacola*
WILEY M. SAMS, M.D...D-54.....*Miami*
DAVID W. GODDARD, M.D...B-56.....*Daytona Beach*

TUBERCULOSIS AND PUBLIC HEALTH*

RALPH S. SAPPENFIELD, M.D., Chm...AL-53.....*Miami*
PHILLIP W. HORN, M.D...B-53.....*Jacksonville*
ERASMUS B. HARDEE, M.D...D-54.....*Vero Beach*
LOUIS J. GARCIA, M.D...C-55.....*Tampa*
HARRY S. HOWELL, M.D...A-56.....*Lake City*

*SPECIAL ASSIGNMENT

1. Diabetes Control

STATE CONTROLLED MEDICAL INSTITUTIONS

William D. Rogers, M.D., Chm...A-56....*Chattahoochee*
James L. Anderson, M.D...AL-53.....*Miami*
Bailey B. Sory, Jr., M.D...D-53.....*Palm Beach*
James G. Lyerly, M.D...B-54.....*Jacksonville*
Samuel G. Hibbs, M.D...C-55.....*Tampa*

MATERNAL WELFARE

E. Frank McCall, M.D., Chm...B-56.....*Jacksonville*
T. Bert Fletcher, Jr., M.D...AL-53.....*Tallahassee*
Lowrie W. Blake, M.D...C-53.....*Bradenton*
John N. Sims, Sr., M.D...A-54.....*Live Oak*
Ralph W. Jack, M.D...D-55.....*Miami*

CHILD HEALTH

Luther W. Holloway, M.D., Chm...B-53....*Jacksonville*
James R. Boulware, Jr., M.D...AL-53.....*Lakeland*
Warren W. Quillian, M.D...D-54.....*Coral Gables*
Daniel F. H. Murphey, M.D...C-55.....*St. Petersburg*
Courtland D. Whitaker, M.D...A-56.....*Marianna*

CONSERVATION OF VISION

Ralph N. Greene, Jr., M.D., Chm...AL-53..*Jacksonville*
William Y. Sayad, M.D...D-53.....*West Palm Beach*
Sherman B. Forbes, M.D...C-54.....*Tampa*
G. Tayloe Gwathmey, M.D...B-55.....*Orlando*
Mozart A. Lischkoff, M.D...A-56.....*Pensacola*

ADVISORY TO WOMAN'S AUXILIARY

C. Robert DeArmas, M.D., Chm...B-55....*Daytona Beach*
Benjamin H. Sullivan, M.D...AL-53.....*St. Petersburg*
Edward F. Shaver, M.D...C-53.....*Tampa*
James L. Anderson, M.D...D-54.....*Miami*
Taylor W. Griffin, M.D...A-56.....*Quincy*

REPRESENTATIVES TO INDUSTRIAL COUNCIL*

Charles R. Burbacher, M.D., Chm...D-55..*Coral Gables*
Fred H. Albee, Jr., M.D...AL-53.....*Orlando*
G. Frederick Oetjen, M.D...B-53.....*Jacksonville*
Chas. L. Farrington, M.D...C-54.....*St. Petersburg*
Lee Sharp, M.D...A-56.....*Pensacola*

*SPECIAL ASSIGNMENT

1. *Industrial Health*

COUNCILOR DISTRICTS AND COUNCIL

Eugene G. Peek, Jr., M.D., Chm...AL-53.....*Ocala*
First—Francis M. Watson, M.D...1-54.....*Marianna*
Second—Benjamin A. Wilkinson, M.D...2-53..*Tallahassee*
Third—William C. Thomas, Jr., M.D...3-54..*Gainesville*
Fourth—Eugene L. Jewett, M.D...4-53.....*Orlando*
Fifth—Hugh G. Reaves, M.D...5-53.....*Sarasota*
Sixth—Emmett E. Martin, M.D...6-54.....*Haines City*
Seventh—Erasmus B. Hardee, M.D...7-54....*Vero Beach*
Eighth—Donald W. Smith, M.D...8-53.....*Miami*

GRIEVANCE COMMITTEE

Walter C. Payne, M.D., Chm.....*Pensacola*
David R. Murphey, Jr., M.D.....*Tampa*
Herbert E. White, M.D.....*St. Augustine*
Joseph S. Stewart, M.D.....*Miami*
William C. Thomas, Sr., M.D.....*Gainesville*

ADVISORY TO SELECTIVE SERVICE FOR PHYSICIANS AND ALLIED SPECIALISTS

J. Rocher Chappell, M.D., Chm.....*Orlando*
Thomas H. Bates, M.D..."A".....*Lake City*
Frank L. Fort, M.D..."B".....*Jacksonville*
Alvin L. Mills, M.D..."C".....*St. Petersburg*
John D. Milton, M.D..."D".....*Miami*

EMERGENCY MEDICAL SERVICE

James V. Freeman, M.D., Chm.....*Jacksonville*
Merritt R. Clements, M.D..."A".....*Tallahassee*
Vernon A. Lockwood, M.D..."B".....*St. Augustine*
Herschel G. Cole, M.D..."C".....*Tampa*
Frederick K. Herpel, M.D..."D".....*West Palm Beach*

A.M.A. HOUSE OF DELEGATES

Homer L. Pearson, Jr., M.D., Delegate.....*Miami*
Frank D. Gray, M.D., Alternate.....*Orlando*
(Terms expire Dec. 31, 1952)

Louis M. Orr, II, M.D., Delegate.....*Orlando*
Joshua C. Dickinson, M.D., Alternate.....*Tampa*
(Terms expire Dec. 31, 1953)

Herbert L. Bryans, M.D., Delegate.....*Pensacola*
Thomas H. Bates, M. D., Alternate.....*Lake City*
(Terms expire Dec. 31, 1954)

BOARD OF PAST PRESIDENTS

William E. Ross, M.D., 1919.....*Jacksonville*
H. Marshall Taylor, M.D., 1923.....*Jacksonville*
John C. Vinson, M.D., 1924.....*Fort Myers*
John S. McEwan, M.D., 1925.....*Orlando*
H. Mason Smith, M.D., 1926.....*Tampa*
John A. Simmons, M.D., 1927.....*Arcadia*
Frederick J. Waas, M.D., 1928.....*Jacksonville*
Julius C. Davis, M.D., 1930.....*Quincy*
William M. Rowlett, M.D., Chm., 1933.....*Tampa*
Homer L. Pearson, Jr., M.D., 1934.....*Miami*
Herbert L. Bryans, M.D., 1935.....*Pensacola*
Orion O. Feaster, M.D., 1936.....*Renton, Wash.*
Edward Jelks, M.D., 1937.....*Jacksonville*
W. Henry Spiers, M.D., 1938.....*Orlando*
Leigh F. Robinson, M.D., 1939.....*Fort Lauderdale*
Walter C. Jones, M.D., 1941.....*Miami*
Eugene G. Peek, Sr., M.D., 1943.....*Ocala*
John R. Boling, M.D., 1944, 1945.....*Tampa*
Shaler Richardson, M.D., 1946.....*Jacksonville*
William C. Thomas, Sr., M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne, M.D., 1949.....*Pensacola*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey, Jr., M.D., Sec'y., 1951.....*Tampa*

From Our President

What Do You Think?

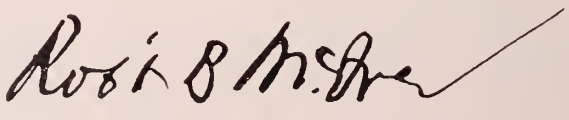
With sights set on the 1953 Annual Meeting to be held in Hollywood next April, the official staff of the Association is busily engaged in planning constructively for the successful culmination of the present year's work. One important step in that direction of interest to all members of the Association is a meeting to be held next month.

On Sunday, December 14, at the Orange Court Hotel in Orlando, the Committee on Scientific Assembly and Specialty Group Problem will meet to confer upon the advisability of altering the present plan of Scientific Assemblies and Specialty Group Meetings at the annual conventions of the Association. An open forum will afford all members the opportunity of expressing their views on this vital matter. They are urged to give the Committee the benefit of their suggestions and considered judgment at this meeting so that its report to the House of Delegates may reflect as fully as possible the wishes of the entire membership.

In accordance with a resolution presented by the Orange County Medical Society and adopted by the House of Delegates at the 1952 Annual Meeting, as Chairman of the Board of Governors I appointed this Committee. Its membership consists of Dr. Herbert E. White of St. Augustine, Chairman, and Drs. Jere W. Annis of Lakeland, Reuben B. Chrisman, Jr., of Miami, Frederick K. Herpel of West Palm Beach, Louis M. Orr, II, of Orlando, R. Wynn S. Owen of St. Petersburg, James N. Patterson of Tampa, Shaler Richardson of Jacksonville, and William C. Roberts of Panama City. Dr. White, the Chairman, will communicate with the members of the Association about the meeting.

The resolution points out that most specialty societies hold their annual meetings on the weekend immediately preceding the Annual Meeting of the Association. Many of their members leave on the first day of the Association's meeting, and it is contended that the attendance upon the scientific sessions is affected. Since the scientific sessions should be set up for the greatest benefit of all the members, the resolution seeks careful evaluation of the problem by this Committee with the cooperation of the entire membership.

Not alone the presidents and secretaries of all county medical societies and of all specialty groups, but each and every member of the Association is urged to give thoughtful consideration to this matter and then voice his opinion to the Committee at the Orlando meeting scheduled for 11 a.m. on December 14. What do you think about it, Doctor?



The Journal of the
Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. BOX 1018 JACKSONVILLE, FLORIDA

Editor
Shaler Richardson, M.D.

Assistant Editors
Webster Merritt, M.D.
Franz H. Stewart, M.D.

Assaciate Editors

Louis M. Orr, II, M.D. ..... Orlondo
Joseph J. Lowenthol, M.D. ..... Jacksonville
Jere W. Annis, M.D. ..... Lokeland
Herschel G. Cole, M.D. ..... Tompo
Wilson T. Sowder, M.D. ..... Jacksonville
Carlos P. Lamor, M.D. ..... Miomi
Walter C. Payne, M.D. ..... Pensacola

Managing Editor
Stewart G. Thompson, D.P.H.
Ernest R. Gibson, Asst.

Committee on Publicotion

Shaler Richordson, M.D., Choirmon ..... Jacksonville
Chos. J. Collins, M.D. ..... Orlondo
James N. Patterson, M.D. ..... Tompa

Abstract Deportment

Kenneth A. Morris, M.D., Choirmon ..... Jacksonville
Wolter C. Jones, M.D. ..... Miomi

Taking Stock

In the midst of spacious grounds, there stands in a small mid-Western city a stately mansion of early nineteenth century vintage. It serves that thriving manufacturing center today as the City Hall, and all who come and go are reminded that the doughty New England pioneer who sought and won his fortune in that Western outpost of his day was aware that he succeeded not in his own strength alone. Beautifully carved on the mantel of the fireplace in the great hall are these words, "God's providence is mine inheritance." He did not fail to give thanks to the Source of his blessings.

In this month of football extravaganzas and turkey dinners, America traditionally pauses to observe Thanksgiving Day. Formally, by presidential proclamation, she acknowledges her manifold blessings. Every individual citizen likewise would do well to take stock of the bounty that is his in this land of, as yet, freedom and abundance. Before partaking of his Thanksgiving feast, every American might appropriately emulate the Founding Fathers of this great nation by placing first upon his empty plate five grains of corn, symbolic of the struggle for survival of the Pilgrims in their quest for freedom.

God's providence has indeed been the heritage of this nation, called today into a position of world leadership. Let America not squander this heritage. Rather, because of it, may she ward off external threats and insidious onslaught from within. May she draw back in time from the yawning abyss of entangling alliances and foreign ideologies which threaten disaster in these days of unprecedented peril. Let her continue to chart her course in the strength of the beneficent Providence which has made her strong and thereby measure up fully to the large place into which she has been called.

The medical profession also may well count its blessings at this appropriate season. In this healthiest of nations, the average life span has increased 20 years in the last half century. The level of medical education here is unsurpassed anywhere in the world, as are standards set for hospital and medical care. Medical research has made remarkable progress, and the battle against many diseases has been or is being won. The encroachment of government in medicine constitutes the one outstanding sinister note. As we give thanks for the achievements to which we may point with pardonable professional pride, let us gird ourselves for teamwork in fighting the battles that lie ahead, secure in the providential guidance which is our heritage. Let us ever be mindful that a charge to keep we have.

Important Court Decision in Hoxsey Cancer Case

Of wide interest to physicians is the opinion of the United States Court of Appeals for the Fifth Circuit in the case of U. S. v. Hoxsey Cancer Clinic, a Partnership, and Harry M. Hoxsey, an Individual, which was handed down at New Orleans recently. This opinion resulted from an appeal in a vigorously contested case tried in the United States District Court at Dallas, Texas, and reverses the judgment of the lower trial court judge. It directs that Court to issue an injunction prohibiting the defendants from distributing in interstate commerce brownish-black, and pink, liquids intended for the treatment of cancer in man.

The Hoxsey Cancer Clinic, opened in 1936, is located in Dallas and ships its products to patients in practically every state in the country. Its "Medical Director," an osteopath named Dr. Joseph Durkee, testified that during his association with it during the past five or six years, he personally had examined and treated five or six thousand patients, at the rate of 35 to 50 a day. At the time of the trial the fee was $400 per patient.

Many physicians across the nation are being asked about the Hoxsey medicines, one of which is for internal and the other for external treatment. That for external use, reports the Division of Medicine of the Food and Drug Administration of the Federal Security Agency, is composed of several escharotics and was not an issue in the trial. Of the two medicines for internal use, the black or brown medicine contains cascara sagrada, potassium iodide, extracts of buckthorn, prickly ash, red clover blossom, alfalfa, sugar and water; the pink liquid is chiefly elixir of lactated pepsin containing variable amounts of potassium iodide. "Supportive treatment" consists of preparations containing iron, urinary antiseptics, vitamins, laxatives and antacids.

The unanimous opinion of the Court of Appeals was that "the overwhelming weight of the credible evidence requires a conclusion that the representation that the Hoxsey liquid medicines are efficacious in the cure of cancer is*** false and misleading. The evidence as a whole does not support the finding of the trial Court that 'some it cures, and some it does not cure, and some it relieves somewhat.'" In addition to distinguished medical specialists, more than 50 physicians from throughout the country gave of their time to testify for the government, enabling it to present scientific evidence that Hoxsey's claimed "cures" were allegedly effected in (1) patients who had never had cancer and were treated at the Hoxsey Clinic for it, (2) those cured of cancer before being treated for it there, and (3) those who had cancer and still have it or who died under the Hoxsey treatment.

In a letter with enclosures to State Health Officers, C. W. Crawford, Commissioner of Food and Drugs, presented the foregoing information and enumerated the important principles laid down in the Circuit Court opinion, based on testimony by cancer experts. These principles are:

1. "*** there is only one reliable and accurate means of determining whether what is thought to be cancer is, in truth and fact, actually cancer. This requires a biopsy, a microscopic examination of a piece of tissue removed from the infected and diseased region."

2. "***the opinion of a layman as to whether he has, or had, cancer, or a like opinion as to whether he has been cured and no longer bears the disease, if, in fact, it ever actually existed, is entitled to little, if any, weight."

3. "***despite the vast and continuous research which has been conducted into the cause of, and possible cure for, cancer the aggregate of medical experience and qualified experts recognize in the treatment of internal cancer only the methods of surgery, X-ray, radium and some of the radioactive by-products of atomic bomb production."

4. "***Upon such subjects a Court should not be so blind and deaf as to fail to see, hear and understand the import and effect of such matters of general public knowledge and acceptance, especially where they are established by the overwhelming weight of disinterested testimony***."

This Court of Appeals decision greatly strengthens the hand of the government in its fight against worthless cancer treatment. Under the law, however, the defendants still have the right to petition for review by the United States Supreme Court.

Electric Vaporizing Devices for Insecticides Present Health Hazards

Several types of generators of insecticide vapors or fumes are now advertised or proposed for use in homes, food establishments, industrial plants, hospitals and schools. The devices commercially available include automatic, thermostatically controlled and manually controlled electric vaporizers which operate continuously, unless the light bulb or heating element serving as the source of heat is turned off. Growing general concern over the efficacy and safety of these electric vaporizing units for the dispersion of insecticides within buildings prompted a recent evaluation of the available data by the Committee on Pesticides of the Council on Pharmacy and Chemistry of the American Medical Association.[1]

In the report of this committee it is explained that the electrically operated thermal generators employ technical DDT, lindane, or a mixture of the two in an inert base with a composition which may include substances such as glycols, carbowaxes, bentonite, or other clays. From a cup in the generator the insecticidal ingredients are evaporated by a built-in heating element or some other heat source, such as an electric light bulb. For the automatic, thermostatically controlled apparatus, the recommended rate of discharge is 1 Gm. of insecticide in 15,000 cu. ft. for a 24 hour period. Under comparable conditions, greater concentrations may be expected with the more inadequately controlled, manually operated machines.

Discharged as vapors or fumes, these ingredients ultimately recrystallize on the ceiling, walls, and other exposed surfaces in varying amount and surface distribution pattern. Loose crystals may even become dislodged and fall to the floor or other horizontal surfaces below, a tendency greatest with devices employing DDT. The atmospheric dispersal of the vapors or fumes is likewise irregular. It is estimated that "if the average active person breathes approximately 10 cu. m. of air in an eight hour period, the maximum theoretical intake of insecticide may be approximately 1.3 to 13 mg. of DDT or 0.9 to 2 mg. of lindane during a normal work-day period." The DDT level in the atmosphere ("0.13 to 1.3 mg. [0.009 to 0.09 ppm] per cu. m. of air when dispensed by a properly operating, thermostatically controlled machine") approaches a concentration which might be considered to exceed a safe level for continuous exposure over a prolonged period of time. The lindane concentration ("0.09 to 0.2 mg. [0.008 to 0.017 ppm] per cu. m. of air") is below the estimated safe level, although regular and continuous exposure is considered unwise.

Taking cognizance of the health problems associated with the use of these devices, the Interdepartmental Committee on Pest Control, composed of representatives of the Departments of Agriculture, Interior, and Defense and the Federal Security Agency, issued a statement recently on the health hazards of the automatic "vaporizer." It recommended use of such devices employing DDT, BHC (benzene hexachloride), or mixtures of the two only where human exposure is on a normal working day basis, as in commercial establishments, and at a rate not to exceed 1 Gm. to 15,000 cu. ft. for a 24 hour period. Other recommendations included caution against continuous exposure to the devices and against their use in homes and sleeping quarters.

Since this statement was issued, the Committee on Pesticides of the Council has received a number of reports of poisoning. Urticaria, mild peripheral neuritis, severe headache, nausea and irritation of the eyes, nose and throat have been reported in employees of food-dispensing establishments, industrial workers and others.

Limited federal regulatory power has led several states and municipalities to recognize the urgency of this problem at the state and local level and to consider ordinances and other types of appropriate regulations.

1. Health Hazards of Electric Vaporizing Devices for Insecticides, J. A. M. A. 149:367-369 (May 24) 1952.

The Case of Patient Versus Case

Is the case admitted to the hospital, or is the patient? Does the case have a fever, or does the patient? Is the case operated on, or is the patient? Ask the patient, and he is apt to vote for himself. Ask the doctor, and he may take a less personal, even less accurate view.

A case is a particular instance of disease, the totality of the symptoms and of the pathologic and other conditions. A patient, on the other hand, is the human being afflicted. Much medical literature to the contrary notwithstanding, proper medical writing restricts the use of the word case to the broad concept of an instance or example of disease, the totality of what is known about the patient, his condition and all the circumstances. One medical dictionary (Dorland's) takes the trouble to add to the definition of case that "a

case is not synonymous with a patient, for the latter is the human being affected with the disease." Moreover, the patient and his condition are the concrete subjects with which one deals, and referring to them specifically rather than to the abstract term case will simplify and vivify writing.

Too, care in this particular may serve as a reminder that, after all, patients are persons, not an assembly of symptoms. It has been pointed out that a major difficulty with modern medical education is "a tendency to teach that man can be understood exclusively through an unfolding of his inherited biological endowment in a given physical setting." A recent report[1] of the American Psychiatric Association points out that "this viewpoint fails to take into account human personality and the influence of interpersonal and cultural factors on personality development and physiological functions."

The pendulum, however, now tends to swing in the right direction, so that physicians of the future will peer right through the laboratory reports and the clinical charts to see the patient himself in the light of his feelings, his fears and his personal problems as well as his aches and pains. In leading medical schools today, the undergraduate medical student studies the principles of psychiatry. Commending this training as evidence of a correct trend, the report indicates that he needs to have a much broader concept of human biology in order to use his training effectively in dealing with patients as persons.

It appears that in the future the case of patient versus case will tend more and more to be decided in favor of the patient.

1. Treat Patients as Persons, Science News Latter 61:395 (June 21) 1952.

A. M. A. Coordinating Committee Disbands Whitaker and Baxter Resign

Its primary objective attained, that of warning the American public of the evils of compulsory health insurance and making known the advantages of the American way of voluntary health insurance, the Coordinating Committee of the American Medical Association was recently dissolved by an action of the Board of Trustees. This Committee has been supervising the National Education Campaign for the past four years. Dr. Elmer L. Henderson of Louisville, past president of A. M. A., has served as chairman since its inception.

The west coast public relations firm of Whitaker and Baxter, which has been doing an outstanding job of directing the National Education Campaign, has resigned and no longer has any official connection with the A. M. A. American physicians, in fact citizens in every walk of life, owe an everlasting debt of gratitude for the effective, efficient and courageous campaign this firm waged in the face of formidable opposition.

Whitaker and Baxter have accepted the assignment of directing the National Professional Committee for Eisenhower and Nixon. This new professional committee will seek to enlist physicians, dentists, lawyers, engineers, pharmacists, accountants and other professional men and women in an aggressive, bipartisan drive for the election of the Republican nominees for president and vice president. Dr. Henderson will serve as chairman of this new committee. He will be aided by A. M. A. past presidents Drs. Ernest E. Irons, Chicago, and John W. Cline, San Francisco, in the capacty of vice chairmen.

Other vice chairmen, who are also past presidents of their respective national professional associations, include: Harold J. Gallagher, New York, American Bar Association; Dr. Clyde E. Minges, Rocky Mount, N. C., American Dental Association; Robert Lincoln McNeil, Philadelphia, American Pharmaceutical Manufacturers' Association; Sidney L. Stolte, St. Paul, National Society of Professional Engineers; and John F. Forbes, San Francisco, American Institute of Accountants.

Both Dr. Henderson and Whitaker and Baxter severed their official connections with A. M. A. in order that they may individually assist in campaigns for candidates for federal elective offices. Such action is entirely within the rights and privileges of every American citizen.

The A. M. A. as a non-partisan professional organization is barred, both ethically and legally, from participating in national election campaigns. These laws and principles apply equally to F. M. A. and county medical societies. It is a violation of the F. M. A. policies to engage in political activities on any level. Precedence set in the early days of the Association and conscientiously followed down through the years, presumes adherence to this principle.

It is the lawful and bounden duty of medical societies on local, state and national levels to study and analyze medical laws and proposed legislation which will affect the health of the people. Legislators frequently consult medical societies and hometown doctors for advice on matters of

this kind. It is essential that the A. M. A., the F. M. A. and county medical societies keep their members informed so that they will be able to give sound counsel. It equally holds that each member owes it to his country and his profession to study the information assembled and disseminated by his professional organizations to aid him in making decisions.

Doctors may engage in political activities as individuals. However, they have no right, nor any authority, to use the name of the A. M. A., the F. M. A., or their county medical society in this connection. Officers of professional organizations must exercise particular caution that their statements and actions cannot be construed as endorsements by the organizations which they represent.

Well Done, Whitaker and Baxter

It is with deep regret that we say farewell to Whitaker and Baxter as they sever official connections with the A. M. A. The Journal salutes them for a difficult task superbly executed.

Brought into the medical family nearly four years ago to direct the newly conceived National Education Campaign, these two dynamic personalities gave freely of their time and talents in presenting to the American public a story sadly in need of telling. Clem Whitaker and Leone Baxter portrayed the evils of government controlled medicine so effectively that today there is a positive trend, not only toward health insurance the voluntary way, but refreshingly away from socialistic doctrines of all kinds. They, together with the rank and file of American physicians, have sparked a desire to restore this country to sound democratic principles of local autonomy and individual freedom.

We have every confidence that these public relations experts will be eminently successful, whatever their assignment. Our best wishes go with them.

FORTY-SIXTH ANNUAL MEETING
SOUTHERN MEDICAL ASSOCIATION
MIAMI
NOV. 10-13, 1952

A.M.A. Clinical Session Denver, December 2-5

In Denver's newly enlarged Municipal Auditorium, the American Medical Association will open its sixth annual Clinical Session on Tuesday morning, Dec. 2, 1952, with the scientific exhibit, medical motion pictures, the technical exposition and registration. On Tuesday afternoon colored television will be shown, with general lectures in the main auditorium, followed by clinical presentations in eight meeting rooms adjacent to the technical and scientific exhibits. Geared to the general practitioner, the meeting will feature practical demonstrations on various phases of medicine of special value to him.

The scientific exhibit, consisting of some 60 exhibits, will cover a wide range of medical subjects and will provide the general practitioner with a postgraduate course in such subjects as office anesthesia, cardiology, dermatology, endocrinology, gynecology, laboratory procedures, otolaryngology, pediatrics and proctology. Emphasis will be on diagnosis and treatment. At stated times, mannikin demonstrations will be given on the problems of delivery. One exhibit will cover fractures of the spine, wrist and ankle. Demonstrations on artificial respiration will use the new back-pressure arm-lift method.

Clinical presentations during the four day session include nearly 200 lectures on obstetrics, pediatrics, diseases of the chest, cardiovascular diseases, neurology and psychiatry, fluid balance and renal problems, traumatic surgery, and medical therapy. In addition, eminent guest speakers from various sections of the country will lecture on hypertension, bone tumors, urinary infections in children, methods of parenteral protein feeding, and other basic subjects.

Colored television, originating from Denver General Hospital, will bring the operating room directly into the convention hall.

The technical exposition on the arena floor will be conveniently located adjacent to the registration desks and two of the meeting rooms.

Physicians may plan to attend a full day of activities without leaving the auditorium for restaurant facilities will be available in the building. There will be a diversified entertainment program each evening.

On Monday, December 1, the day preceding the opening of the Clinical Session, the annual Medical Public Relations Conference will be held.

FLORIDA BLUE SHIELD

A Message To Blue Shield Physicians

The first Medical Society-Blue Shield Liaison Committee meeting to be held since the organization of the committees throughout the State took place in Miami on August 27, 1952, and was a joint meeting of the Dade and Broward County committees. Blue Shield president Dr. Leigh F. Robinson's message to the joint gathering so well described the background and purposes of Blue Shield and its close affiliation with the medical profession that his message is reprinted for the benefit of all physicians.

"I believe that the county committees appointed by the medical societies are an important step toward maintaining the understanding between participating physicians and the Blue Shield Plan. Every medical society has members who have not had the opportunity to become familiar with Blue Shield. It is particularly for this group of physicians that the county Blue Shield committees can be most helpful whenever questions are asked regarding the why and wherefore of Blue Shield.

"Many laymen and some physicians, because of lack of knowledge, labor under the impression that the medical profession sponsored Blue Shield for the purpose of insuring payment of their bills. Nothing could be further from the truth. On the contrary, the members of the medical profession became interested in voluntary health insurance because they became very frightened in the 30's and 40's that the Washington government was going to be successful in passing a compulsory type of health insurance. Congressmen and Senators over the United States who were unfavorable to socialization of medicine told their doctor friends back home that opposition in Congress to compulsory health insurance was doomed to crumble unless something could be offered in its place. The doctors were told by their friends in Congress who were close to the pulse of the people that a voluntary type of prepayment health insurance would be preferred by the American public, and although commercial companies were offering group health plans they offered too little to meet the arguments of the proponents of governmental compulsory health insurance. Surveys of group employers and employees indicated that the average man in the low income bracket wanted a package type of coverage which would protect him against catastrophic conditions which required hospitalization. These employer groups indicated that they desired a medical plan for meeting medical bills similar to that which was being offered by the Blue Cross for the prepayment of hospital bills. These groups further indicated that such a coverage must guarantee to the low income worker, (1) full payment of all surgical bills requiring hospitalization, and, if possible, maternity bills, (2) a low premium rate, and (3) guarantee that the medical profession woud agree to render the services offered by the Plan.

"It was in the middle 30's when these arguments were being spread by both the lay and medical press throughout the country. The American Medical Association was being criticized by the profession for not initiating a medical care plan as the American Hospital Association had done in sponsoring Blue Cross. The doctors throughout the country became so impatient with the apparent delay of the American Medical Association that they began organizing small surgical plans on county and state medical society levels. Almost immediately these groups of physicians were astonished by the popularity and success of their Plans. The favorable comment of both the lay and medical press and the growing demand of large groups of employees and employers for this new type of health coverage stimulated state medical societies all over the United States to sponsor for their areas similar health plans. The movement once underway progressed far beyond their fondest hopes and expectations. Today, there are very few communities in the United States and Canada that are not served by these health plans, now known as Blue Shield Plans.

"In the beginning the only experience and actuarial tables were those possessed by commercial companies offering surgical and maternity coverage which, as shown above, were employed by the Blue Shield Plans. As the movement has expanded some of the larger Plans whose reserves permitted experimentation have been offering additional medical benefits. Our own Plan, acting upon the experience of larger Plans, has added during the past two years some medical benefits. At the present time a committee is making a survey of all benefits, especially medical benefits, of commercial and Blue Shield Plans throughout the United States and Canada in order to learn whether or not it will be feasible for Florida Blue Shield to increase its medical and other services. It should be emphasized that this desire of the Florida Blue

Shield to add other types of benefits for the subscriber is only for the purpose of increasing the value of the policy to the subscriber. In other words, the policy of your Blue Shield is, and must always be, to give the subscriber first and last consideration in the expenditure of the subscriber's money. This means that any increase of benefits of Blue Shield must be for the subscriber and not necessarily for the doctor. This at first may seem illogical because it would appear that any increase of benefits to the subscriber would benefit the doctor, or on the other hand, any increase of fees for the doctor would also benefit the subscriber. This is not always true, because an increase of fees to the physician could weaken and make insolvent the Plan. The doctor should, and in most cases does, feel that he is well remunerated because he is a link in the chain that has stymied to date all governmental efforts to impose socialized medicine on the public.

"In closing, I want to express my appreciation to each and every one of you for accepting an appointment on your County Medical Society Blue Shield Committee and to assure you that the directors, officers and the executive director are always at your command."

BIRTHS AND DEATHS

Births

Dr. and Mrs. James J. Hutson of Miami announce the birth of a son, Micah Graham, on May 8, 1952.

Dr. and Mrs. S. Roy Higginbotham, Jr., of Tampa announce the birth of a daughter, Kathleen Lynn, on Aug. 21, 1952.

Dr. and Mrs. Theodore J. Grable of Tampa announce the birth of a son, William DeTar, on Aug. 22, 1952.

Dr. and Mrs. William W. Trice of Tampa announce the birth of a son.

Deaths — Other Doctors

McKey, Earle S., Jr., Valdosta, Ga. April 28, 1952

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Britt, Otis W., Tallahassee
Davis, H. Clinton, Miami
Harris, Tyndall P., Jacksonville
McCallister, Archie, Jr., Miami
McShane, James K., Jr., Miami
Ramey, John R., Miami
Saxon, Roy F., Jr., Tampa
Wolkowsky, Melvin, Miami Beach
Zipser, Lester L., Tampa

STATE NEWS ITEMS

Dr. Herbert E. White, St. Augustine, chairman of the Committee on Scientific Assembly and Specialty Group Problem, has called a meeting open to all members of the Association at 11 a.m. on Sunday, Dec. 14, 1952, at the Orange Court Hotel, Orlando. The purpose of this meeting is to consider the advisability of rearranging the set-up on scientific assemblies and specialty group meetings at the Association's annual meeting. Every member interested in this problem is urged to attend the meeting.

Consideration of this problem is a result of an action by the House of Delegates at Hollywood in April 1952 when it approved a resolution introduced by the Orange County Medical Society, "That the Board of Governors appoint a committee to consider this problem during the coming year and report to the 1953 session of the Florida House of Delegates."

Following the close of the open forum for all members of the Association, the Committee will retire to prepare a report for presentation at the 1953 meeting of the House of Delegates.

In addition to Dr. White, President McIver has appointed the following members on this Committee: Drs. Jere W. Annis, Reuben B. Chrisman, Jr., Frederick K. Herpel, Louis M. Orr, II, R. Wynn S. Owen, James N. Patterson, Shaler Richardson and William C. Roberts.

The many friends of Dr. Joseph S. Stewart, Miami, will be pleased to learn that his presidential address presented during the Atlanta Assembly of The Southeastern Surgical Congress, Atlanta, March 10-13, 1952, has been published in the June 1952 issue of the American Surgeon.

In his inimitable style, Dr. Stewart has reviewed our rich American heritage with particular emphasis upon the part the South has contributed to that heritage. The wisdom written into the Constitution by its framers is portrayed. In conclusion the medical profession is advised of its responsibility, along with other dutiful citizens, to work diligently and constantly in order to protect this heritage and preserve the Constitution from the inroads of socialistic doctrines.

Dr. Thos. S. Griggs, formerly of Miami Shores, has started the second year of his residency in anesthesia at Charity Hospital, New Orleans.

Upon invitation from the Southern Medical Association, the F. M. A. Committee on Public Relations will have a booth at the annual meeting, November 10-13, in Miami, to show some of the highlights of the Association's public relations program. Dr. Eugene B. Maxwell, Tampa, chairman of the Committee on Public Relations, has arranged for the exhibit which will be manned by personnel from the Bureau of Public Relations.

Dr. John M. Schultz, 2300 Biscayne Boulevard, Miami, recently returned from New York City after an extended leave of absence, taking special work in different forms of therapy for gynecolgical ccnter, etc. Dr. Schultz will limit his practice to sterility and Gynecology.

The Florida Obstetric and Gynecologic Society will hold its Third Annual Mid-Winter Scientific meeting at the Soreno Hotel in St. Petersburg, Saturday afternoon and Sunday morning, December 6 and 7. The guest speaker will be Dr. John Nokes, Associate Professor of Obstetrics and Gynecology, the University of Virginia Department of Medicine.

Dr. Rene A. Torrado of Miami Beach spoke on cancer over radio station WMBM recently. He was guest speaker on the Hungarian-American Culture Club program.

Appearing on the WTVJ television program "Modern Living" in September were Drs. Joseph J. Groom of Miami who spoke on "Cataracts;" Harold Rand of Miami who spoke on "Emotions and Allergies;" Howard A. Engle of Miami Beach who spoke on "Cerebral Palsy;" and Carl M. Midkiff of Miami Shores who spoke on "Food Poisoning."

Dr. Frank G. Slaughter of Jacksonville spoke on "Disease and Destiny" at a recent meeting of the Mandarin Community Club.

Dr. Edward R. Annis of Miami recently addressed the Miami Acacia Club on "Let's Live a Little Longer."

Dr. J. M. Ingram, Jr., of Tampa has been named chairman of the executive committee of the Hillsborough County Unit of the American Cancer Society. He succeeds Dr. C. Frank Chunn of Tampa who has resigned from active service on the committee after serving as its chairman since its organization three years ago.

A new portable exhibit designed for lay audiences and entitled, "Health — 1952" is available from the A. M. A.'s Bureau of Exhibits for state and county medical societies. The exhibit presents an over-all picture of health conditions in the United States at the present time. The Bureau plans to revise and bring the exhibit up to date each year. The only cost involved to medical societies will be the shipping charges both ways.

Dr. Lorenzo L. Parks of Jacksonville, Commander of the 202nd Medical Battalion of the Florida National Guard, announces that any physician who is interested in devoting a small amount of time to the Florida National Guard may do so by contacting one of the Florida National Guard Units in his home town or near by for information. As this Journal goes to press, physicians in Priority 3 may become members of the National Guard and then they are not subject to the draft. Physicians not living in a town where there is a National Guard Unit may be assigned appropriate duty and make drills in neighboring towns.

Drs. Hawley H. Seiler, Tampa, and DeWitt C. Daughtry and John G. Chesney of Miami were among the speakers at the Thirty-Ninth Annual Southern Tuberculosis Conference at the Roney Plaza Hotel in Miami Beach recently.

Dr. Franklin J. Evans of Coral Gables recently spoke on the WTVJ "Law of the Land" program.

Dr. George F. Schmitt, Jr., of Miami spoke at a recent meeting of the South Miami Lion's Club. His subject was "The Wellspring of Your Existence."

Drs. Clarence Bernstein and Solomon D. Klotz of Orlando recently presented a special report to the Annals of Allergy, which appears in the July-August issue of that journal. The study covered four years of work with a new antihistamine drug.

Dr. Valpeau H. Ragsdale of Pierce was recently honored for long and faithful service by the communities within a 15-mile radius of Pierce. The program included a picnic, speech-making and entertainment, and was held at the Pierce Community Center.

A most cordial welcome awaits physicians of the South attending the Miami meeting of the Southern Medical Association. The meeting will consist of forty-nine half-day sessions presented by the twenty-one sections of the Association, which embrace every phase of medical practice. In addition to the section sessions there will be a general session, the annual dinner of the Association and outstanding scientific and technical exhibits.

This meeting will be the opportunity of the year for physicians of the South to attend a complete general medical meeting and at the same time enjoy a much-needed vacation during one of the most delightful periods of the year in beautiful Miami.

All activities of this meeting will be in the Municipal Auditorium in Bayfront Park and in near-by hotels, everything within walking distance. Good hotel accommodations are available for all who wish to attend this outstanding medical meeting.

Regardless of what any physician may be interested in, regardless of how general or how limited his interest, there will be at Miami a program to challenge that interest and make it worthwhile for him to attend.

Members of state and county medical societies may attend. Eligible physicians, members of state and county medical societies in the South can be and **should** be members of the Southern Medical Association. The annual dues of $10.00 include the Southern Medical Journal, a journal most valuable to physicians of the South, one that each should have on his reading table.

SOUTHERN MEDICAL ASSOCIATION
Empire Building
Birmingham 3, Alabama

Dr. Eugene B. Maxwell of Tampa, chairman of the Association's Committee on Public Relations, met with a group of Tallahassee physicians October 8 in Tallahassee to discuss preparations for showing the Association's Fair Exhibit at the North Florida Fair, October 27-November 1. Tom Jarvis, assistant supervisor of the Association's Bureau of Public Relations, also attended the meeting.

Dr. Joseph H. Lucinian of Miami has returned to his practice after attending a meeting on roentgenology in Houston, Tex.

Dr. James T. Cook, Jr., of Marianna presided recently at the first meeting of the executive board of the local P.-T.A. Dr. Cook is president of the board.

Dr. Meyer Yanowitz of Miami spoke on "Common Aids in Dermatologic Practice," at a recent meeting of the Miami chapter of the Florida Society of Medical Technologists.

Dr. Shaler Richardson, Jacksonville, chairman of the Medical Advisory Committee to the Florida Council for the Blind, and Drs. Charles C. Grace, St. Augustine; Sherman B. Forbes, Tampa; Bascom H. Palmer, Miami, and Nathan S. Rubin, Pensacola, members of the Committee, met with the Boardmen of the Council in Daytona Beach recently.

The Association's display, "My Doctor," was shown at the annual conference of county and home demonstration agents from all over the state, October 5-10, in Gainesville. A series of six illustrations based on the physician's requirements as set forth in the A. M. A.'s Principles of Medical Ethics, the display originally was used during the recent Farm and Home Institute meetings at Camp Timpoochee, near Niceville, and Camp Cherry Lake, near Madison. The showing at Gainesville was part of the Association's Rural Educational Program.

Dr. Robert B. McIver of Jacksonville, as president of the Jacksonville Blood Bank, accepted on behalf of the Blood Bank, a certificate of achievement for having collected 10,719 pints of blood for the Armed Forces Blood Program on October 8.

Dr. Frank E. Wilson, Director; Mr. James Foristel, attorney of the A. M. A. Washington office; and Dr. Julian Price, Florence, S. C., a member of the A. M. A. Committee on Legislation, met in Jacksonville on October 15 with key members of the Florida and Georgia state medical associations and their woman's auxiliaries.

The primary objective of the meeting was to acquaint the medical leaders of the two states with the latest information on the national legislative picture. This Florida-Georgia meeting is one of a series being conducted throughout the United States by representatives from the A. M. A. Washington office.

Dr. Carlos P. Lamar of Miami, representing the Dade County Medical Association, spoke at a public meeting sponsored jointly by the "Alianza Interamericana" and the "Mental Health Society of South Florida" on September 7. Following the showing of the film, "City Hospital," Dr. Lamar spoke on "Psychosomatic Medicine" and discussed the film.

Dr. W. Wardlaw Jones of Dade City spoke to the Dade City Rotary Club at a recent luncheon meeting. His subject was the county hospital and its needs.

Dr. David R. Murphey, Jr., of Tampa has been appointed chairman of the local medical and nursing subcommittee for the 1952-53 Red Cross disaster organization.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

WANTED: Capable, successful, Michigan G. P. desires opportunity in Palm Beach, Fort Lauderdale or Miami. Forty-two years, married, two children. Florida license. Will invest. Write 69-67, P. O. Box 1018, Jacksonville, Fla.

ASSOCIATION DESIRED: Veteran, married, Baptist, 32, completing 4th year University Hospital surgical residency, Board qualified now, individual or group, preferably northern or middle coastal. Write 69-70, P. O. Box 1018, Jacksonville, Fla.

WANTED: General Practitioner for northeast section of Miami. Office equipped. Excellent opportunity. Write 69-72, P. O. Box 1018, Jacksonville, Fla.

WANTED: Physician retired from private practice desires staff position hospital for mental diseases. Available now. Work interest supplemental to substantial income. Write care P. O. Box 790, Raleigh, N. C.

FOR SALE: Closing Office. Late model 100 milliampere radiographic-fluoroscopic x-ray machine complete, perfect condition and like new; also 110 volt x-ray therapy unit complete. Bargains at fraction present market. Write 69-73, P. O. Box 1018, Jacksonville, Fla.

COMPONENT SOCIETY NOTES

Dade

At the regular October meeting of the Dade County Medical Association, a symposium on pediatric cardiology was held. Participating were Drs. Herbert Eichert who spoke on "Facilities Available in Dade County," Milton S. Saslaw who spoke on "Rheumatic Heart Disease in Miami (Studies and Views)," Francisco A. Hernandez who spoke on "Cardiac Catheterization (Method and Value)," and Jack L. Wright who spoke on "Activities of a Diagnostic Service."

DeSoto-Hardee-Highlands-Glades

At the regular September meeting of the DeSoto-Hardee-Highlands-Glades County Medical Society, which was held at Aqua Vitae Springs, Zolfo, guest speakers were Drs. Wesley W. Wilson and Leffie M. Carlton, Jr., both of Tampa. Dr. Wilson spoke on "Skin Tumors About the Eyelids," and Dr. Carlton spoke on "Cancer of the Lung."

Duval

At the regular meeting of the Duval County Medical Society in October, Dr. Jack Mickley, medico-legal expert of Harvard University, spoke on the legal problems that might be encountered by a physician in his practice.

Hillsborough

At the regular meeting of the Hillsborough County Medical Association on October 7, Dr. J. M. Ingram, Jr., spoke on "Occult Rupture of the Uterus."

Lake

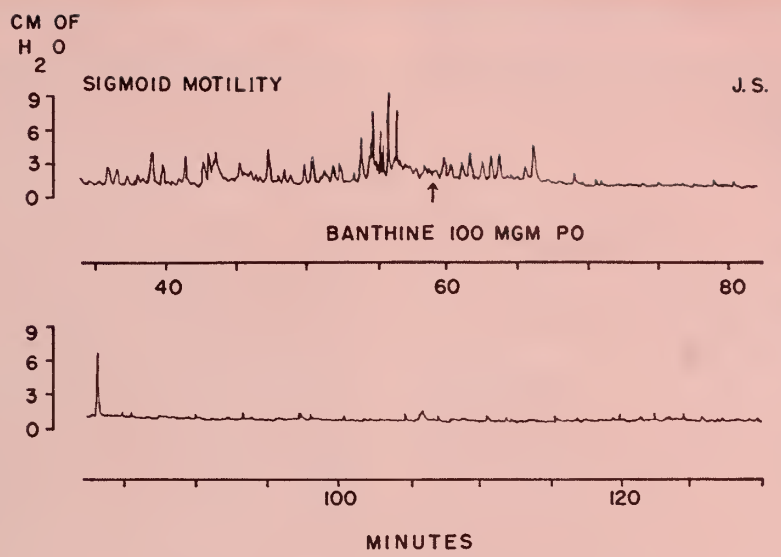
At the September meeting of the Lake County Medical Society, Dr. Robert W. Young of Orlando spoke on "Arthritis."

Marion

At the regular September meeting of the Marion County Medical Society, Dr. Chester A. Fort, assistant urologist, Emory Medical College, Atlanta, spoke on "The Present Indications for Uretero-Intestinal Anastomosis."

Monroe

At a recent joint meeting of the Monroe County Medical Society and the staff of the United States Naval Hospital in Key West, Drs. John Elliott and Donald W. Smith, of Miami, spoke on research and clinical work in shock condition. Dr. Smith also read a paper on "Nitrogen Balance in Critically Ill Patients."



The effect of 100 mg. of Banthine on sigmoid motility. The contractions did not return during the experimental period.[1]

In Intestinal Hypermotility—Banthine®

"...has a prolonged inhibitory effect on human gastrointestinal motility....
The duration of its action is striking,...."[1]

It has also been observed that definite retardation in gastrointestinal transit time in individuals with hypermotility was attributable to the therapeutic effect of Banthine.[2]

BANTHINE® Bromide (brand of methantheline bromide)—a true anticholinergic—is available for oral and parenteral use.

1. Kern, F., Jr.; Almy, T. P., and Stolk, N. J.: Effects of Certain Antispasmodic Drugs on the Intact Human Colon, with Special Reference to Banthine (β-Diethylaminoethyl Xanthene-9-Carboxylate Methobromide), Am. J. Med. *11*:67 (July) 1951.

2. Lepore, M. J.; Golden, R., and Flood, C. A.: Oral Banthine, an Effective Depressor of Gastrointestinal Motility, Gastroenterology *17*:551 (April) 1951.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Advertisement

From where I sit *by* Joe Marsh

Going . . . Going . . . Almost Gone

Granny Robinson put on quite a show the other night at the White Elephant auction at the Women's Club.

Towards the end of the evening, she had the ladies really battling for anything she put up. "What am I bid for this woman's lovely black coat here—good as new? Who'll say ten dollars?" she asked.

Granny held the coat up, and commenced describing the lining, sleeves, buttons—really "selling hard." Then, suddenly, she took a *close* look and blurted out "Land sakes, no more bidding—this is *my own* coat!"

From where I sit, what almost happened to Granny was good for a laugh, but sometimes when people "get carried away" with their own talk it's not so funny. Like those who would tell others how to practice their profession . . . like those who would interfere with my right to a temperate glass of beer. I suggest we hold on to our opinions—and believe in them—but take a close look at them before we try to "sell" them to our neighbor!

Joe Marsh

Copyright, 1952, United States Brewers Foundation

WOMAN'S AUXILIARY
TO THE
FLORIDA MEDICAL ASSOCIATION
OFFICERS

MRS. HERSCHEL G. COLE, President.....*Tampa*
MRS. THOMAS C. KENASTON, President-elect.....*Cocoa*
MRS. RICHARD F. STOVER, 1st Vice Pres.....*Miami*
MRS. NELSON A. MURRAY, 2nd Vice Pres.....*Jacksonville*
MRS. REAVES A. WILSON, 3rd Vice Pres.....*Sarasota*
MRS. TAYLOR W. GRIFFIN, 4th Vice Pres.....*Quincy*
MRS. ALBERT G. LOVE, IV, Recording Sec'y.....*Gainesville*
MRS. HERBERT B. LOTT, Correspd. Sec'y.....*Tampa*
MRS. SAMUEL S. LOMBARDO, Treasurer.....*Jacksonville*

COMMITTEE CHAIRMEN

MRS. CHARLES F. HENLEY, Finance.....*Jacksonville*
MRS. EDWARD F. SHAVER, Today's Health.....*Tampa*
MRS. ALVIN L. MILLS, Legislation.....*St. Petersburg*
MRS. C. RUSSEL MORGAN, JR., Public Relations.....*Miami*
MRS. WILLIAM G. MERIWETHER, Reference.....*Plant City*
MRS. SHERREL D. PATTON, Civil Defense.....*Sarasota*
MRS. CARROLL V. HERRON, Projects.....*Daytona Beach*
MRS. JULIUS ALEXANDER, Program.....*Miami*
MRS. JAMES T. COOK, JR., Bulletin.....*Marianna*
MRS. GEORGE H. PUTNAM, Historian.....*Gainesville*
MRS. ANGUS D. GRACE, Parliamentarian.....*Fort Myers*
MRS. ALFONSO F. MASSARO, Revisions.....*Tampa*
MRS. JOHN E. MAINES, JR., Stu. Loan Fund....*Gainesville*
MRS. ARTHUR R. KNAUF, Medalx.....*Tampa*
MRS. CHARLES McD. HARRIS, JR., Study Group.....*W. P. Beach*
MRS. C. ROBERT DeARMAS, Auxiliary Writer for State Medical Journal.....*Daytona Beach*
MRS. EDWARD W. CULLIPHER, Stu. Nurse Recruit. *Miami*
MRS. LEFFIE M. CARLTON, JR., Hospitality.....*Tampa*

The Time Has Come

The A. M. A. National Education Campaign is officialy ended by action of the Board of Trustees. Four vital, constructive years were spent in this educational endeavor by members of the medical profession and their lay representatives.

It was an historic undertaking. In its great crusade against socialization, it stood like a beacon of liberty with arm uplifted pointing the way out of legislative meshes which were being knit about the body medicine.

This activity made a landmark in the history of American medicine. It meant the difference between life and suffocation of the profession and preservation of the principles in which it believes. It was effective because of combined efforts of millions of individuals from every group, who stood united in resistance to a compulsory system which threatened the freedom and safety of the nation's health under the misleading nomer of insurance.

The results of this educational campaign became evident in the accelerated growth of voluntary health insurance plans which evinced the healthy vigor of a people who prefer to choose a method of self-protection rather than wear the yoke of a compulsory measure.

Dr. Elmer L. Henderson, chairman of the American Medical Association's Coordinating

Committee, which has supervised the campaign against socialized medicine, has resigned his committee chairmanship so that he may be free to participate in the presidential election campaign. Clem Whitaker and Leone Baxter, Directors of the A. M. A. National Education Campaign, have asked to be released from their duties for the same reason.

For, it must be remembered, the A. M. A. is a nonpartisan, professional organization and is barred both ethically and legally from participating in election campaigns. Dr. Henderson and Whitaker and Baxter, in asking for their release from A. M. A. duties, do so in order that they may be free to participate in the campaign. This is the right of every individual.

Neither the A. M. A. nor the F. M. A. will take part in the presidential election except to join with other nonpartisan groups in urging all eligible voters to cast their ballots on election day regardless of their affiliations or preference. However, a doctor and his wife are entirely free to participate in election activities as individuals. In fact there is a real responsibility to make their influence felt in the interest of good government.

For, in having wrestled with socialism and discouraged it at the gates of medicine, we can be sure this ideology will creep in another entrance and like in the fable of Beowulf who did battle with Grendel, we see depicted a monster whose appetite was fed on the vigour of the nation's vitality — its independence. Its approach was concealed under a fog, its method was to lull to sleep; placing a spell upon those who slept to make them sleep more soundly. The responsibility falls to the Beowulfs of every age who by effort manage to see what manner of thing this socialistic Grendel is.

The legends of old are timeless because they immortalize the constant struggle between good and evil and the obligation of man is summed up in the words of Hygelac: "The time has come, O Beowulf, for you to prove your worth. The Gods have gifted you with the strength of thirty men, and this strength you should use to the advantage of your fellows. . . . Our neighbor is in sore need. Go forth and do mortal combat with this Grendel-fiend."

Mrs. C. Robert DeArmas

Migraine In Children

"Migraine may appear during the first years of life. The presence of subjective signs, such as headache and flimmer scotoma, is often difficult to determine in young children. The true nature of the symptoms frequently remains obscure for years."

Vahlquist, B. and Hackzell, G.: Acta Paediatrica *38*: 622 (1949).

NO. OF CASES	SEX	AGE AT ONSET	CYCLIC VOMITING	DURATION OF ATTACK	INTENSITY
31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNILATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

(reference given above)

In a study of 400 adult migraine patients, it was revealed that 34% had suffered attacks before the age of 15.* These investigators concluded that childhood migraine was a much greater clinical problem than was previously believed and that psychodynamic mechanisms played an important part in the disease.

These criteria are useful in diagnosis:

Headache attacks with symptom-free intervals plus (at least two of the following) nausea, scintillating scotoma, hemicrania, and hereditary predisposition.

For symptomatic relief in these cases, Cafergot®, N.N.R. (ergotamine with caffeine) may be administered orally. For best results, give adequate dosage promptly.

For children within the age range 7 to 12 years—Cafergot® is administered, one tablet when the attack appears imminent followed by one additional tablet within 30 minutes. Not more than two Cafergot tablets should be administered to children within this age range.

In the adolescent age group, 12 to 18 years of age, the dosage may gradually be increased as necessary up to the usual adult dose, i.e., two tablets when the attack appears imminent followed by one tablet doses at half hour intervals until the attack is aborted. *(Total maximum dose for adults: six tablets for each attack.)*

*Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. *50*: 2269 (Oct.) 1950.

Sandoz Pharmaceuticals
DIVISION OF SANDOZ CHEMICAL WORKS, INC.
68 CHARLTON STREET, NEW YORK 14, N. Y.

OBITUARIES

Herbert Raphael Mills

Dr. Herbert Raphael Mills of Tampa died at St. Joseph's Hospital in that city on June 27, 1952 after an illness of several months.

Dr. Mills was born in Albion, Mich., on Oct. 19, 1882, the son of Henry Albert and Ella Fallass Mills, both of his native state. His father, who was a talented artist, served as director of the Art School at Albion College and at DePauw University in Greencastle, Ind., and Cornell College in Mount Vernon, Iowa.

After receiving a general education in the public schools of Indiana and New York State, Dr. Mills matriculated at Cornell College in Iowa, from which he was graduated, and then attended Rush Medical College, which is now part of the University of Chicago. He received his degree of Doctor of Medicine from this institution in 1910 and the same year came to Tampa, where he became director of the local laboratory of the Florida State Board of Health, a post in which he served until the United States entered the World War. At this time he retired to enlist in the Medical Corps of the United States Army, joining this branch of the service in July 1917. He was commissioned a first lieutenant and sent overseas, where he was to serve for two years, during which time he was loaned to the British Army for five months, being identified with the 24th Royal Fusiliers and the 5th Brigade of the Royal Field Artillery. He then returned to the American forces and served with the Army of Occupation, in which he was assigned to the 1st Division in February 1918. Later he was promoted to the rank of captain and served as a field hospital officer in Germany until the summer of 1919, when he returned to the United States, being honorably discharged from the Army during the month of July of that year.

Upon resuming civilian life he returned to Tampa and re-entered his profession, specializing in pathology. In 1946, Dr. James N. Patterson, on his discharge from the Armed Forces, joined

BALLAST POINT MANOR

Care of Mild Mental Cases, Senile Disorders
and Invalids
Alcoholics Treated

Aged adjudged cases will be accepted on either permanent or temporary basis.

ACCREDITED HOSPITAL FOR NEUROLOGICAL PATIENTS by
American Medical Assn.
American Hospital Assn.
Florida Hospital Assn.

5226 Nichol St.
Telephone 62-2332

DON SAVAGE
Owner and Manager

P. O. Box 10368
Tampa 9, Florida

with Dr. Mills to form the firm of Drs. Mills and Patterson. Dr. Mills was a member of the Hillsborough County Medical Association, the Florida Medical Association, the Florida Society of Pathologists and the American Medical Association. Since its inception in 1942, Dr. Mills was the Medical Director of the Southwest Florida Blood Bank. He was a Founding Fellow of the College of American Pathologists and a Fellow of the American Society of Clinical Pathologists. Dr. Mills was a Diplomate of the American Board of Pathology, being certified in both clinical pathology and pathologic anatomy. He was a member of Delta Tau Delta fraternity and Phi Beta Phi medical fraternity.

Aside from his profession, his greatest interest rested in nature and wild life. In 1946 the State Chamber of Commerce awarded him the Gold Medal of Conservation in appreciation of his outstanding work in this field. He had championed preservation and protection of all types of wild life and also done much to help the Indian population of the state. In these connections he was a member of the National Audubon Society and the Florida State Audubon Society, in which he was a member of the executive committee. Dr. Mills also belonged to the American Ornithologists Union. He was appointed by the United States Biological Survey to assist in the making of a nationwide census of ducks, the survey accomplishing much of the work by airplane. As a member of the Seminole Indian Association, he belonged to a group whose purpose it has been to help the Indian population of this state in every possible way.

Dr. Mills is survived by his widow, Marie-Louise; a son, H. Robin, who is a student at the Florida State University; and a sister, Miss Ermina M. Mills of Greencastle, Ind.

Harold Fritz McDuffie

Dr. Harold Fritz McDuffie of Jacksonville died on March 4, 1952 in a Daytona Beach hospital. He was 61 years of age.

Dr. McDuffie was born in Fayetteville, N. C., in 1890. He received his medical training at the New York Medical College, from which he received the degree of Doctor of Medicine in 1913. He then served an internship at Flowery Branch Hospital in New York City.

Before coming to Florida to reside, Dr. McDuffie practiced medicine in Atlanta, Ga. He was a member of the staff of the Georgia Baptist Hospital and of St. Joseph's Infirmary. In 1944 he located in Jacksonville, where he specialized in ophthalmology and otolaryngology. He was a member of the Elks Club and of the Baptist Church.

Dr. McDuffie was a member of the Duval County Medical Society, the Florida Medical Association and the American Medical Association.

Surviving are the widow, Mrs. Ossie Virginia McDuffie of Jacksonville; one daughter, Miss Mary Elizabeth McDuffie of Atlanta; two stepdaughters, Miss June King and Miss Georgia King of Jacksonville; four sons, Randy Warren McDuffie of Jacksonville and Bruce McDuffie, Robert Stanley McDuffie and Harold Fritz McDuffie, Jr., all of Atlanta; and three brothers, P. C. McDuffie of Atlanta, Allen McDuffie of Asbury Park, N. J., and Morgan McDuffie of Ocean Grove, N. J.

Errata

The correct date of the death of Dr. Arthur Jones Logie of Miami is June 13, 1952.

Cook County Graduate School of Medicine

ANNOUNCES COURSES FOR FALL AND WINTER 1952-1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting November 3, January 19, February 2. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 2. Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 16. Surgery of Colon & Rectum, One Week, starting November 17, March 2. Bronchoscopy, One Week, by appointment. General Surgery, One Week, starting February 9. General Surgery, Two Weeks, starting March 30. Fractures & Traumatic Surgery, Two Weeks, starting March 2.

GYNECOLOGY—Intensive Course, Two Weeks, starting February 16. Vaginal Approach to Pelvic Surgery, One Week, starting March 2.

OBSTETRICS—Intensive Course, Two Weeks, starting November 3, March 2.

MEDICINE—Intensive General Course, Two Weeks, starting May 4. Gastroscopy & Gastroenterology, Two Weeks, starting November 3.

UROLOGY—Two Week Intensive Course starting April 27. Ten-Day Practical Course in Cystoscopy starting every two weeks.

DERMATOLOGY—Intensive Course, Two Weeks, starting May 4.

Teaching Faculty:
Attending Staff of Cook County Hospital
Address: Registrar, 707 South Wood Street
Chicago 12, Illinois

. . . Part of Your "Overall" Pict

Luzier's Bath and Body Service

Not so very long ago, we r
garded bathing more than on
a week as sheer self indulgenc
Then, as we became more enlightened, we realized that a daily bath is essential to go
grooming. Similarly, Bath and Body preparations, once regarded as luxuries, are now re
ognized as necessities. No woman need and no woman should be satisfied with anythi
less than head-to-foot loveliness. Our body-beautiful preparations, delightfully scente
may be obtained through your Luzier Cosmetic Consultant.

Luzier's Fine Cosmetics and Perfumes

Are Distributed in Florida by:

PFEIFER & PFEIFER, DIVISIONAL DISTRIBUTORS

235 North Main Street

Phone: 3-3636, Orlando, Florida

DISTRICT DISTRIBUTORS

MARTHA MATTHEWS
Box 3754
St. Petersburg, Florida
Phone: 75-8242

LOUISE SMITH
1414 E. Central
Orlando, Florida
Phone: 7520

RUBY FATULA
Box 775
Orlando, Florida
Phone: 9898

REESE T. VERMILYA
Box 2334
West Palm Beach, Florida
Phone: 8069

MAY LUCAS
3404 Cherokee St.
Tampa 9, Florida
Phone: 62-6234

AGNES BRAMLETT
3875 Walsh St.
Jacksonville, Florida
Phone: 2-1575

ROBERTA CHATEAUNEUF
1419 West Ave.
Miami Beach, Florida
Phone: 58-7407

Meat...

and its Wide Clinical Applicability

That meat is an important component of the high protein diet[1] employed in the treatment of many pathologic states is evident from the following dietary suggestions that have been recommended by some authorities in the field of nutrition:

Protein of good quality and in adequate amounts is the most effective dietary agent for protecting the liver from damage and for promoting its repair.[2] In the long-term management of chronic liver disease, a suggested diet includes at least 4 ounces of lean lamb, veal, or beef in both the noon and evening meals.[3]

Among the nutritional needs of patients with chronic ulcerative colitis is protein.[4] For such patients a recommended diet includes 4 ounces of tender meat with luncheon and with dinner.[5a]

In diabetes mellitus, maintenance of protein reserves is important for supporting well-being and vigor, for maintaining resistance to infection, and, in conjunction with good general management, for minimizing many of the degenerative changes commonly seen in this condition.[6,7] One ounce of bacon at breakfast and 2½ ounces of cooked meat at each of the other two meals are valuable in a diabetic diet.[5b]

A program of treatment[8] found useful in atherosclerosis of the coronary vessels includes an adequate diet low in fat (20-25 Gm. daily) and normal or moderately high in protein (60-100 Gm. daily), in conjunction with lipotropic agents. A sample menu of this diet lists 2 ounces of lean meat at both the noon and evening meals.

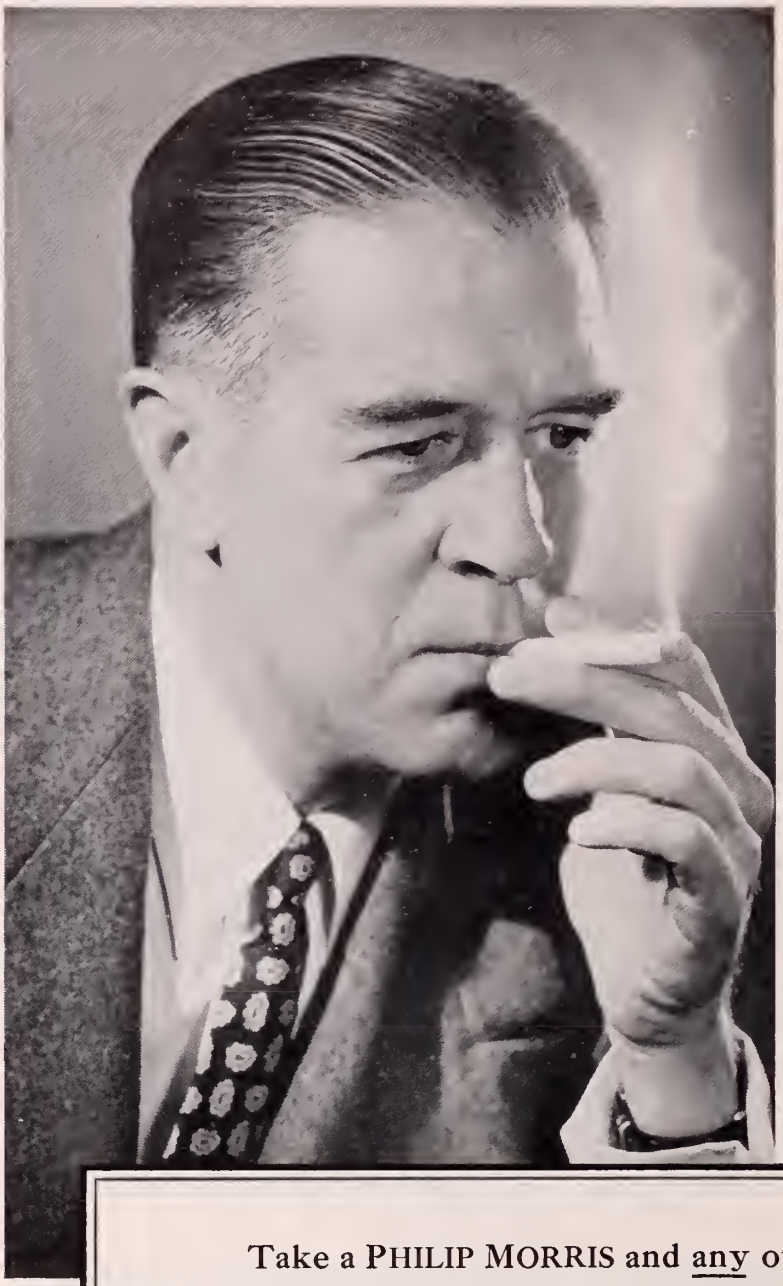
Underweight or average weight patients with persistent low blood sugar levels are benefited by a high protein diet providing meat two or three times a day.[9] In overweight patients of this type, lean meat is served at luncheon and at dinner.

During convalescence from infectious disease, the importance of "high protein-high calorie" diets including generous servings of meat deserves emphasis.[10] For this purpose, a suggested typical daily menu schedule which results in weight gain, improved vigor, and a restored sense of well-being furnishes ½ ounce of bacon at breakfast and 3 ounces of meat at each of the other meals. Supplementary feedings may include additional amounts of meat.

1. Lewis, H. B.: Proteins in Nutrition, in Handbook of Nutrition, American Medical Association, ed. 2, Philadelphia, The Blakiston Company, 1951, p. 1.
2. Patek, A. J., Jr.: Evaluation of Dietary Factors in Treatment of Laennec's Cirrhosis of Liver, J. Mt. Sinai Hosp. *14*:1 (May-June) 1947.
3. Portis, S. A., and Weinberg, S.: Recent Advances in the Medical Treatment of Cirrhosis of the Liver, J.A.M.A. *149*:1265 (Aug. 2) 1952.
4. Welch, C. S.; Adams, M., and Wakefield, E. G.: Metabolic Studies on Chronic Ulcerative Colitis, J. Clin. Investigation *16*:161 (Jan.) 1937.
5. (a) Mayo Clinic Diet Manual, Philadelphia, W. B. Saunders Company, 1949, p. 89.
(b) Ibid., p. 133.
6. Mosenthal, H. O.: Management of Diabetes Mellitus, An Analysis of Present-Day Methods of Treatment, Ann. Int. Med. *29*:79 (July) 1948.
7. McLester, J. S.: Nutrition and Diet in Health and Disease, ed. 5, Philadelphia, W. B. Saunders Company, 1949, p. 364.
8. Morrison, L. M.: Arteriosclerosis: Recent Advances in the Dietary and Medical Treatment, J.A.M.A. *145*:1232 (Apr. 21) 1951.
9. Low Blood Sugar Level; Queries and Minor Notes, J.A.M.A. *149*:1358 (Aug. 2) 1952.
10. Goodman, J. I., and Garvin, R. O.: Results of High Calorie Feeding, Gastroenterology 6:537 (June) 1946.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute
Main Office, Chicago...Members Throughout the United States



Doctor, be your own judge... try this simple test

With so many claims made in cigarette advertising, you, Doctor, no doubt prefer to judge for yourself. So won't you make this simple test?

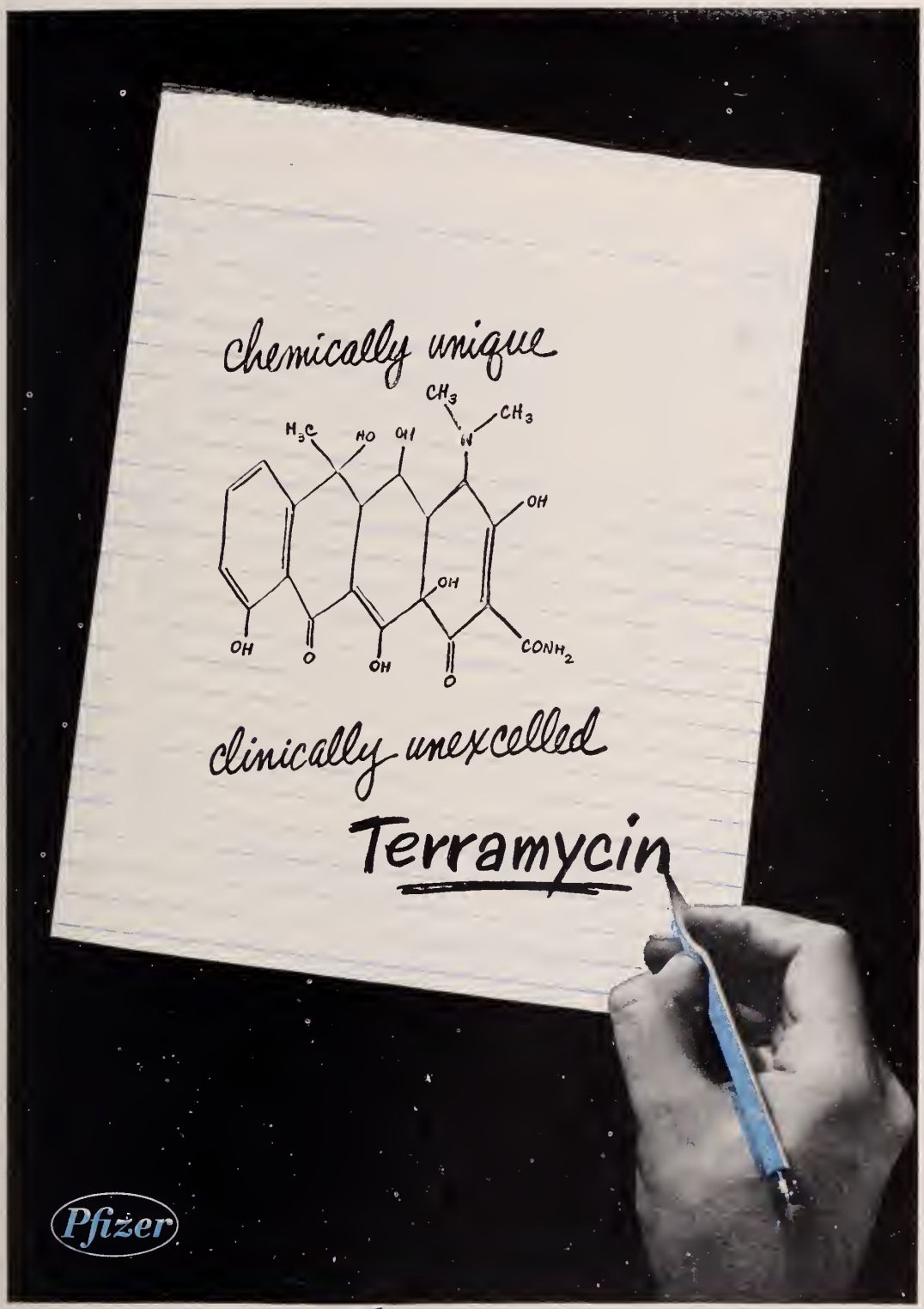
Take a PHILIP MORRIS and any other cigarette

1. Light up either one first. Take a puff—get a good mouthful of smoke—and s-l-o-w-l-y let the smoke come *directly* through your nose.
2. Now, do exactly the same thing with the other cigarette.

You will notice a distinct difference between PHILIP MORRIS and any other leading brand.

PHILIP MORRIS

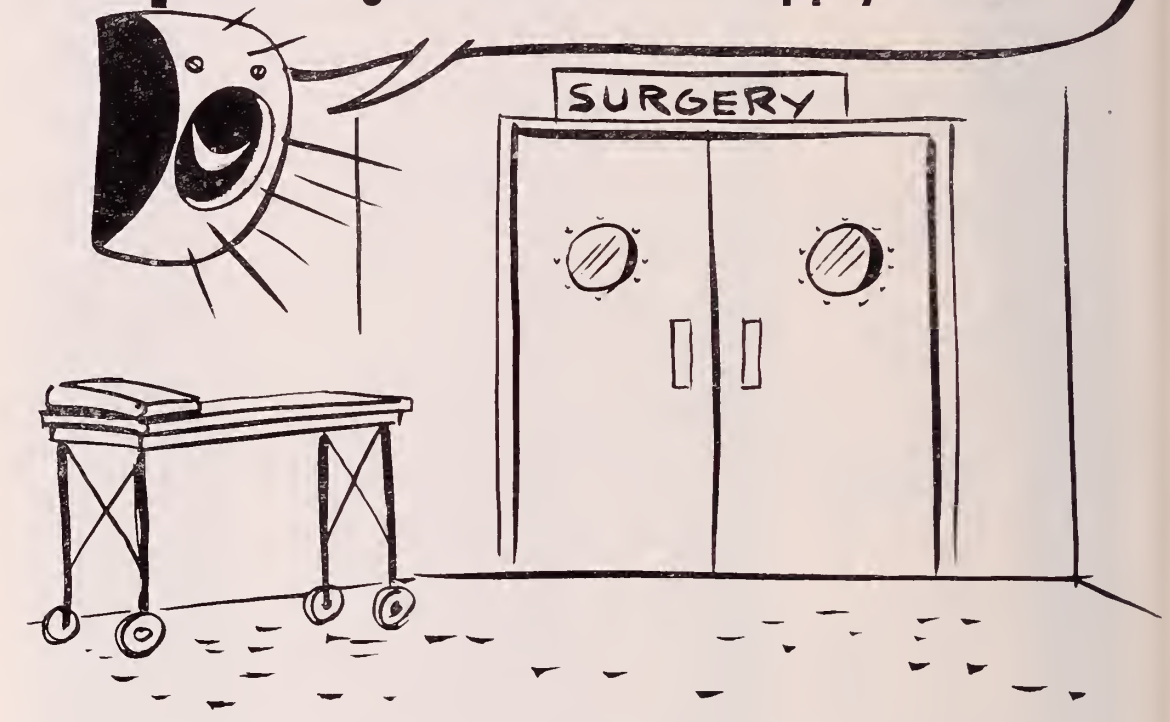
Philip Morris & Co. Ltd., Inc., 100 Park Avenue, New York 17, N. Y.



DON'T MISS

APPEARING REGULARLY IN THE J. A. M. A.

Calling Dr. Brown . . . Emergency!
Calling Dr. Brown . . . Emer–WHOOPS!
Calling the Medical Supply Man!



What's your problem? Need more sutures? A new sphygmomanometer? A quick trouble-shooting job? Could be the Medical Supply Man is already in some other part of the hospital, but if he isn't, a telephone call always brings him in a hurry! That's why you and so many other professional people have learned to depend on him!

Ordinarily the Medical Supply Man has more than 15,000 individual items in stock at all times. And he knows his stock — can get what you want on split second notice. No wonder you get such fast service when you call the Medical Supply Man!

Remember . . . whether you need supplies, new equipment or an expert repair job for some of your old equipment . . . you get best service, fastest service when you obey that impulse and CALL THE MEDICAL SUPPLY MAN!

HOSPITAL, PHYSICIANS and LABORATORY SUPPLIES & EQUIPMENT

MEDICAL SUPPLY COMPANY

Essentials For Scientific Progress

MIAMI • of JACKSONVILLE • ORLANDO

230 N. E. THIRD ST.
MIAMI 32, FLA.

420 WEST MONROE ST.
JACKSONVILLE 2, FLA.

329 N. ORANGE AVE.
ORLANDO, FLA.

The Right to *Choose* . . . .

CORNERSTONE OF AMERICAN LIBERTY

Hospital Expense Plans

AS long as Americans keep the right to choose — their church, their political party, their doctor and their hospital — freedom must prevail.

Medical-Surgical Expense Plans

We are proud that hundreds of thousands of Americans have freely chosen the protection afforded them by PENNSYLVANIA LIFE'S liberal, low-cost health insurance plan.

Paycheck Protection Plans

Pennsylvania Life
HEALTH & ACCIDENT **Insurance Company**

FOUNDED 1890

HOME OFFICE: PHILADELPHIA 5, PA.

Life Insurance Plan

19 District Offices in Florida

Miami	Executive Office	Fort Lauderdale	521½ South Andrew Avenue
	3028 Biscayne Blvd.		
	Downtown	Jacksonville	303 Clark Building
	1210 Pacific Building		
	Southwest	Tampa	228 Cass Street Arcade Building
	1260 S. W. 22nd Street		
	Little River 8340 N.E. Second Ave., Suite 245	Sarasota	237 Main Street, Room 15
	Coral Gables	Fort Pierce	Florida Bank Building, Room 34
	3028 Biscayne Blvd.		
	Miami Beach	Daytona Beach	116½ Orange Avenue
	206 Harvey Building		
St. Petersburg	509 White Building	Tallahassee	429 Centennial Building
Lakeland	206 Marble Arcade	Panama City	142 Harrison Avenue
West Palm Beach	305 Citizens Building	Pensacola	501 Theisen Building
Orlando	209 Slayton Building		

THE EARLE JOHNSON SANATORIUM

For the care of nervous, mental, senile, alcoholic, and addicted cases. **Moderate rates.**

Operated by C. Earle Johnson, Jr., M.D., Psychiatrist-in-Chief, F.A.P.A., F.A.C.P. Diplomate of the American Board of Psychiatry and Neurology.

The most modern and effective psychiatric methods are employed. Gradual reduction in the addictions; Antabuse treatment for alcoholism.

Telephone: 3-3369 or 3-3360
Write: Drawer 106
Meridian, Mississippi

Allen's Invalid Home

MILLEDGEVILLE, GA.
Established 1890
For the treatment of
NERVOUS AND MENTAL DISEASES

Grounds 600 Acres
Buildings Brick Fireproof
Comfortable Convenient
Site High and Healthful

E. W. ALLEN, M.D., *Department for Men*
H. D. ALLEN, M.D., *Department for Women*
Terms Reasonable

CONVENTION PRESS

218 WEST CHURCH STREET
JACKSONVILLE
FLORIDA

Commercial and
Publication
Printing

Janet's Nursery for Babies

P. O. Box 191
OSPREY, FLORIDA
Phone RIngling 4-1647

A Nursery for Handicapped Babies

For Information write
H. KEITH JACOBUS
P. O. Box 191
Osprey, Florida

S. A. Kyle *Funeral Director*

MEMBER
National Selected Morticians
BY INVITATION

17 WEST UNION STREET
JACKSONVILLE 2, FLORIDA
Phones 5-3766 5-3767

MIAMI RETREAT SANATORIUM

FOUNDED 1927

For Nervous and Mental Disorders, Alcohol and Drug Addiction

STAFF OF EIGHT NEUROPSYCHIATRISTS
New X-Ray Diagnostic Treatment Facilities
Comfortable AIR-CONDITIONED rooms, suites

79TH STREET AT MIAMI AVENUE
MIAMI 38, FLORIDA
Phone 7-1824

•In MIAMI SANITARIUM

Medical Hospital American Plan Hotel for Patients and their families. REST, CONVALESCENCE, ACUTE and CHRONIC MEDICAL CASES. Elderly People and Invalids. *FREE Booklet!*

Acres Tropical Grounds, Delicious Meals, Res. Physician, Grad. Nurses, Dietitian.

SUN-RAY PARK HEALTH RESORT

Mild Mental Cases, Drug and Alcoholics in Separate Building

BRAWNER'S SANITARIUM
Established 1910

SMYRNA, GEORGIA
(Suburb of Atlanta)

For Nervous and Mental Disorders
Drug and Alcohol Addiction
Electro-Shock in selected cases

JAMES N. BRAWNER, M.D., Medical Director
ALBERT F. BRAWNER, M.D., Department for Men
JAMES N. BRAWNER, JR., M.D., Department for Women

BISCAYNE HOSPITAL

6339 Biscayne Blvd.
MIAMI 38, FLORIDA

Members of the Dade County Medical Association are acquainted with the high type of service rendered.

David Collins, Superintendent

Registered, American Medical Association
Phone 7-4544

Dilaudid hydrochloride

(dihydromorphinone hydrochloride)

COUNCIL ACCEPTED

Powerful opiate analgesic - dose, 1/32 grain to 1/20 grain.

Potent cough sedative - dose, 1/128 grain to 1/64 grain.

Readily soluble, quick acting.

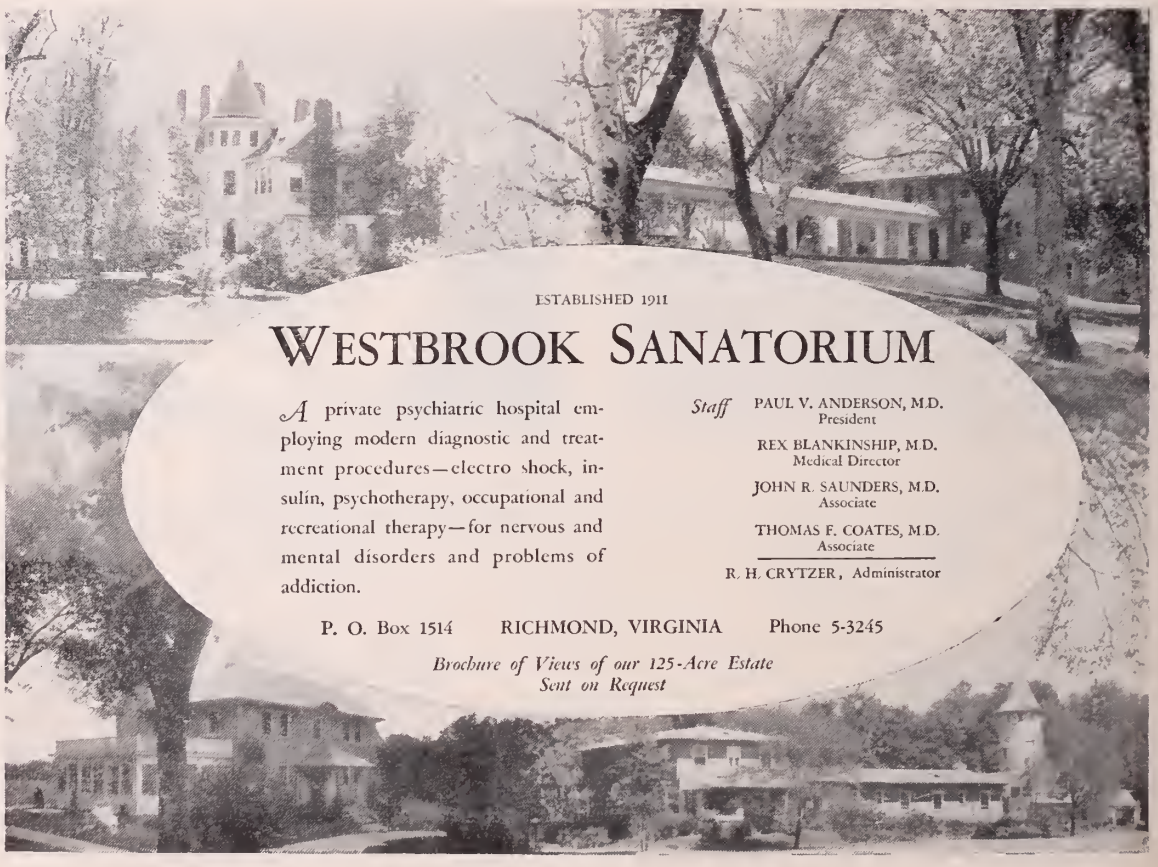
Side effects, such as nausea and constipation, seem less likely to occur.

An opiate, has addictive properties.

Dependable for relief of pain and cough, not administered for hypnosis.

● Dilaudid is subject to Federal narcotic regulations. Dilaudid, Trade Mark Bilhuber.

Bilhuber-Knoll Corp. Orange, N. J.



ESTABLISHED 1911

WESTBROOK SANATORIUM

A private psychiatric hospital employing modern diagnostic and treatment procedures—electro shock, insulin, psychotherapy, occupational and recreational therapy—for nervous and mental disorders and problems of addiction.

Staff
PAUL V. ANDERSON, M.D.
President
REX BLANKINSHIP, M.D.
Medical Director
JOHN R. SAUNDERS, M.D.
Associate
THOMAS F. COATES, M.D.
Associate

R. H. CRYTZER, Administrator

P. O. Box 1514 RICHMOND, VIRGINIA Phone 5-3245

Brochure of Views of our 125-Acre Estate Sent on Request

ONE OF AMERICA'S FINEST INSTITUTIONS . . .

BROOK HAVEN MANOR...

with a well trained staff of nurses and attendants, fills the need for a high class, ethical nursing home.

Convalescents and elderly patients receive individual attention in these lovely surroundings.

Alcoholics, drug addicts and mental patients are not accepted.

Rates moderate based on individual needs.

Dedicated to the Welfare of the Convalescent and Elderly . . .
. . . . . In a Setting of Inviting Friendliness and Simple Grace. . . Elevation 1200 feet

BROOK HAVEN MANOR SANITARIUM

STONE MOUNTAIN, GA.

Mrs. Carro Henderson Miss Elizabeth C. Hancock

HIGHLAND HOSPITAL, INC.

FOUNDED IN 1904

Asheville, North Carolina

AFFILIATED WITH DUKE UNIVERSITY

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a sixty-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D.,
Diplomate in Psychiatry
Medical Director

ROBT. L. CRAIG, M.D.,
Diplomate in Neurology and Psychiatry
Associate Director

HILL CREST SANITARIUM

FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

Thoroughly modern in architecture and construction. Eight departments — affording proper classification of patients. All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

James A. Becton, M.D., Physician-in-charge — James Keene Ward, M.D., Associate Physician

P. O. Box 2896, Woodlawn Station, Birmingham, Alabama — Phones 9-1151 and 9-1152

TUCKER HOSPITAL, INC.

212 West Franklin Street

RICHMOND, VIRGINIA

A private hospital accepting for diagnosis and treatment organic neurological conditions, selected psychiatric and alcoholic cases, metabolic disturbances of an endocrine nature, individuals who are having difficulty with their personality adjustments, and children with behavior problems. Patients with general medical disorders admitted for treatment under our staff of visiting physicians.

Under the Professional Charge of

DR. HOWARD R. MASTERS,
DR. JAMES ASA SHIELD AND ASSOCIATES

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Medical Association	Robert B. McIver, Jacksonville	Samuel M. Day, Jacksonville	Hollywood, Apr. 26-29, '53
Medical Districts	Eugene G. Peek, Jr., Ocala	Council Chairman	
orthwest	Francis M. Watson, Marianna	Benjamin A. Wilkinson, Tallahassee	
ortheast	William C. Thomas, Jr., Gainesville	Eugene L. Jewett, Orlando	
uthwest	Emmett E. Martin, Haines City	Hugh G. Reaves, Sarasota	
utheast	Erasmus B. Hardee, Vero Beach	Donald W. Smith, Miami	
Specialty Societies			
y of General Practice	Edward F. Shaver, Tampa	Frank T. Linz, Tampa	Hollywood, Apr. 26, '53
Society	Nelson Zivitz, Miami Beach	Solomon D. Klotz, Orlando	" "
siologists, Soc. of	John T. Stage, Jacksonville	Breckenridge W. Wing, Orlando	" "
r, Am. Coll. Chest Phys.	Alexander Libow, Miami Beach	DeWitt C. Daughtry, Miami	" "
and Syph., Soc. of	Lewis Capland, Miami Beach	Morris Waisman, Tampa	" "
Officers' Society	George W. Edwards, II, Orlando	Lorenzo L. Parks, Jacksonville	" "
ial & Railway Surgeons	John H. Mitchell, Jacksonville	William H. Chapman, Jacksonville	" "
ogy & Psychiatry	W. Tracy Haverfield, Miami	Roger E. Phillips, Orlando	" "
l Gynec. Society	Dorothy D. Brame, Orlando	J. Champneys Taylor, Jacksonville	" "
l & Otol., Soc. of	Joseph W. Taylor, Sr., Tampa	Carl S. McLemore, Orlando	" "
edic Society	Arthur H. Weiland, Coral Gables	Edward W. Cullipher, Miami	" "
gists, Society of	Robert J. Poppiti, Miami Beach	Alfred E. Cronkite, Fort Lauderdale	" "
ic Society	Egbert V. Anderson, Pensacola	J. K. David, Jr., Jacksonville	W. Palm Beach, Nov. 8-9, '52
ogic Society	Alex. E. Rosenberg, Miami Bch.	George Williams, Jr., Miami	Hollywood, Apr. 26, '53
gical Society	Thomas H. Lipscomb, Jacksonville	A. Judson Graves, Jacksonville	" "
ical Society	George H. Putnam, Gainesville	David W. Goddard, Daytona Beach	" "
Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	
l Banks, Association	Donald W. Smith, Miami	Mr. J. M. Potts, Miami	Miami, May, 1953
Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Daytona Beach, Nov. 16, '52
Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Mother Loretto Mary, Tampa	Hollywood, Apr. 26, '53
er Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Jacksonville, Dec. 7, '52
al Society, State	W. G. McLeod, D.D.S., Pensacola	Coleman Brown, D.D.S., Tampa	St. Petersburg, Apr. 20-23, '53
t Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
ital Association	Mother Loretto Mary, Tampa	Tracy B. Hare, Miami	Daytona Bch., Nov. 17-19, '52
ical Examining Board	Ralph B. Spires, DeFuniak Springs	Homer L. Pearson, Jr., Miami	Jacksonville, Nov. 23-25, '52
ical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
es Association, State	Miss Undine Sams, Miami	Bertha King, Tampa	St. Petersburg, Nov. 14-16, '52
maceutical Association, State	Mr. Clyde Morris, Daytona Beach	Mr. R. Q. Richards, Ft. Myers	St. Petersburg, May, '53
ic Health Association	Mr. Angus Laird, Tallahassee	Mr. Fred B. Ragland, Jacksonville	Tampa, 1953
erculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Elsa B. Conant, Pt. St. Joe	Jacksonville, May, 1953
ian's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	Hollywood, Apr. 26-28, '53
an Medical Association	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	New York, June 1-5, '53
A. Clinical Session	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	Denver, Dec. 2-5, '52
rn Medical Association	R. J. Wilkinson, Huntington, W. Va	Mr. C. P. Loranz, Birmingham	Miami, Nov. 10-13, '52
a Medical Association	B. W. McNease, Fayette	Douglas L. Cannon, Montgomery	Birmingham, Apr. 16-18, '53
n, Medical Assn. of	C. F. Holton, Savannah	Mr. Sid Wrightsman, Atlanta	Savannah, May 10-13, '53
lospital Conference	Mr. Norman Losh, Orlando	Mr. D. O. McClusky, Tuscal'sa, Ala.	New Orleans, April 8-10, '53
astern Allergy Assn.	Clarence Thomas, Nashville, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Havana, Cuba, Mar. 26-29, '53
astern, Am. Urological Assn.	William Miner, Covington, Ky.	Sidney Smith, Raleigh, N. C.	Nashville, May, '53
astern Surgical Congress	H. L. Claud, Washington, D. C.	B. T. Beasley, Atlanta	Louisville, Mar. 9-12, '53
oast Clinical Society	Alvin L. Stebbins, Pensacola	Dale E. York, Pensacola	

MIAMI MEDICAL CENTER

P. L. DODGE, M.D.
Medical Director and President

1861 N. W. South River Drive
Phones 2-0243 — 9-1448

A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures — Psychotherapy, Insulin, Electroshock, Hydrotherapy, Diathermy and Physiotherapy when indicated. Adequate facilities for recreation and out-door activities. Cruising and fishing trips on hospital yacht.

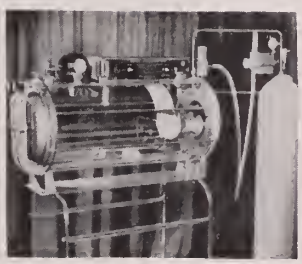
Information on request
Member American Hospital Association

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS Total	MEMBERS Paid	COUNCILO
A	Bay	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	William F. Humphreys, Jr., M.D. 112 E. 3rd Court Panama City		24	100%	
	Escambia *Santa Rosa*	Chas. J. Heinberg, M.D. 109 N. Baylen St. Pensacola	Raymond B. Squires, M.D. 386 Brent Bldg. Pensacola	2nd Tuesday 8:00 P.M.	78	100%	
	Franklin-Gulf	John W. Hendrix, M.D. Port St. Joe	Photis J. Nichols, M.D. Apalachicola	Last Wednesday	7	100%	A-1-54 Francis M. Watson, M.I Marianna
	Jackson-Calhoun	Albert E. McQuagge, M.D. 207 N. Green St. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	16	
	Walton-Okaloosa	William D. Cawthon, M.D. DeFuniak Springs	Edgar H. Myers, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	100%	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		5	100%	
	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	100%	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	Ernest W. Ekermeyer, M.D. 516 N. Adams St. Tallahassee	George H. Massey, M.D. 204 N. Madison St. Quincy	Quarterly 7:30 P.M.	59	55	
	Suwannee	Edward G. Haskell, Jr., M.D. Branford	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak	1st Saturday 9:30 A.M.	9	100%	A-2-53 Benjamin A Wilkinson, M Tallahassee
	Madison	A. Franklin Harrison, M.D. Madison	Eugene D. Thorpe, M.D. Madison		3	100%	
	Taylor *Dixie, Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	3	100%	235
B	Alachua *Bradford, Gilchrist, Union*	Henry J. Babers, Jr., M.D. Box 709 Gainesville	Raymond S. Camp, M.D. 907 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	49	48	
	Duval *Clay*	Ferdinand Richards, M.D. 508 Greenleaf Bldg. Jacksonville	Joseph A. J. Farrington, M.D. 415 Greenleaf Bldg. Jacksonville	1st Tuesday 8:15 P.M.	256	245	
	Marion *Levy*	Carl S. Lytle, M.D. 1206 E. Ocklawaha Ave. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	30	26	B-3-54 William C. Thomas, Jr., M Gainesville
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	11	100%	
	Putnam	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	Bennie J. Massey, M.D. Box 105 Palatka	2nd Tuesday 6:00 P.M.	10	9	
	St. Johns	Charles C. Grace, M.D. 145 King St. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
	Brevard	James A. Sewell, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	23	22	
	Lake *Sumter*	Robert H. Montgomery, M.D. Mount Dora	J. Basil Hall, M.D. Mount Dora	1st Wednesday 7:30 P.M.	26	100%	B-4-53 Eugene L. Jewett Orlando
	Orange *Osceola*	Carl S. McLemore, M.D. 1217 Kuhl Ave. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	154	150	
	Seminole	Julian N. Tolar, M.D. First Street Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	16	100%	
	Volusia *Flagler*	J. Richard West, M.D. 224 S. Palmetto Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	78	77	668
C	Hillsborough	Sherman B. Forbes, M.D. 409 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	175	170	
	Manatee	John E. Granade, M.D. 114 Walcaid Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	18	17	
	Pasco-Hernando- Citrus	William H. Walters, Jr., M.D. Lacoochee	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	16	100%	C-5-53 Hugh G. Reaves Sarasota
	Pinellas	John P. Rowell, M.D. 2500 Driftwood Rd., S. E. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Mon. Even Mo. 1st Fri. Odd Mo. 6:00 P.M.	187	100%	
	Sarasota	Henry G. Morton, M.D. 555 Golf St. Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	2nd Tuesday 8:30 P.M.	44	100%	
	DeSoto-Hardee- Highlands- Glades	Harold S. Agnew, M.D. 705 E. Oak St. Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	26	23	
	Lee-Charlotte- Collier-Hendry	John S. Stewart, M.D. Lee Memorial Hosp. Fort Myers	Harvie J. Stipe, M.D. 210 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	24	23	C-6-54 Emmett F Martin, M. Haines Cit
	Polk	Ivan W. Gessler, M.D. 402 Professional Bldg. Winter Haven	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	91	88	581
D	Indian River	P. T. McClellan, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	6	
	Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Drive West Palm Beach	David A. Newman, M.D. 511 Citizens Bldg. West Palm Beach	3rd Monday 8:00 P.M.	116	100%	D-7-54 Erasmus I Hardee, M. Vero Beac
	St. Lucie- Okeechobee- Martin	Richard F. Sinnott, M.D. 209 Koblegard Bldg. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	15	13	
	Broward	Lloyd U. Lumpkin, M.D. 918 E. Las Olas Blvd. Ft. Lauderdale	William K. Peck, M.D. 915 N. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	83	80	
	Dade	Ralph S. Sappenfield, M.D. 630 duPont Bldg. Miami	Nelson Zivitz, M.D. 311 Lincoln Rd. Miami Beach	1st Tuesday 8:30 P.M.	618	586	D-8-53 Donald W. Smit Miami
	Monroe	James B. Parramore, M.D. Box 326 Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	15	14	854

THE BUNN GLOVE CONDITIONER — This piece of equipment eliminates hand labor connected with drying and powdering each glove. It enables the hospital to cut costs by using a time saving method and preservation of gloves. Gloves are powdered both inside and out.

BUNN M. H. E. REFRIGOMATIC — Is the only oxygen tent which will maintain a relative humidity of 80% or better at reduced temperatures. It has a dual system unit which will both cool and humidify.

THE BUNN VAPOMATIC UNIT — May be used to produce relative humidity of 85% to any tent or incubator.



THE BLOXSOM AIR LOCK — This unit now uses an improved air injector regulator and it is no longer necessary to have compressed air to operate the unit. Only oxygen is necessary.

MEMBER

AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A.

Anderson Surgical Supply Co.

Established 1916

Telephone 5-8391
40-42 W. DUVAL STREET
P. O. Box 1799
JACKSONVILLE 1, FLORIDA

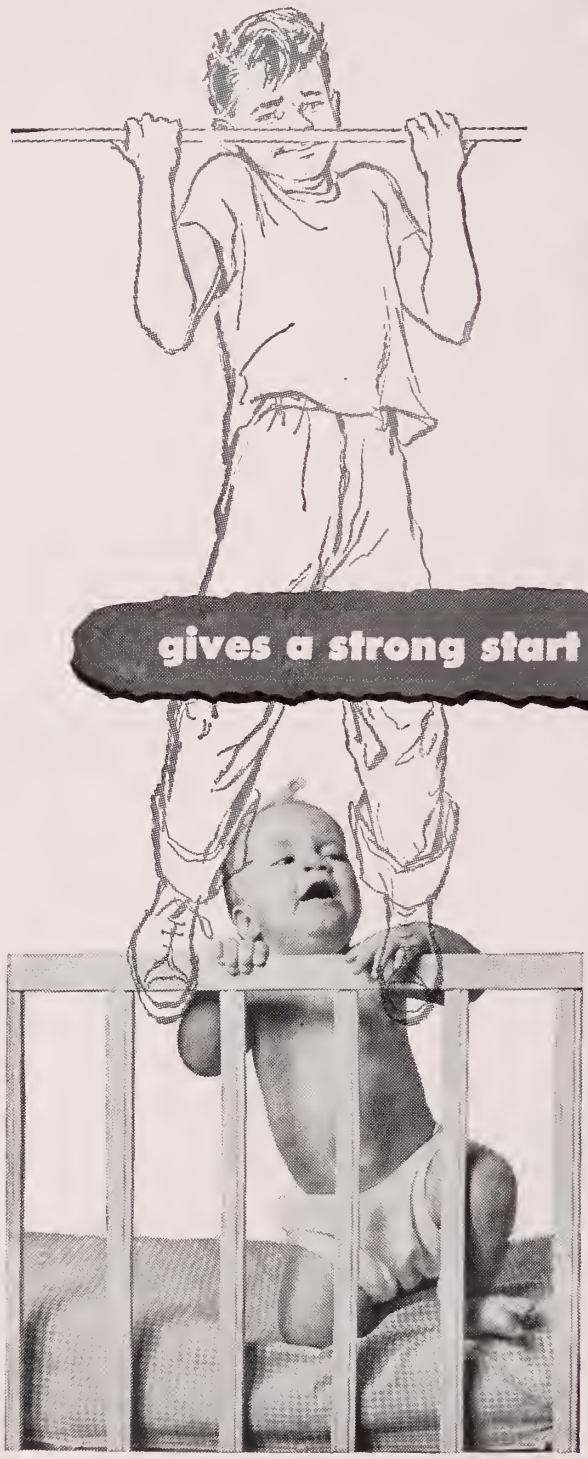
Telephone 2-8504
1101-1105 TAMPA STREET
P. O. Box 1228
TAMPA 1, FLORIDA

Telephone 7-4589
21 3rd STREET N.
ST. PETERSBURG, FLORIDA

NEW YORK ACADEMY OF 2
MEDICINE
2 E 103RD ST
NEW YORK N Y 29 J C-E

Olac

Mead's powdered formula designed for both full term and premature infants



gives a strong start for a healthy childhood

Excellent tissue turgor and muscle development in babies fed Olac® are clearly shown by steadily increasing clinical observations. These babies tend to gain weight without becoming fat, are sturdy, and resist infections well. They are generally vigorous, with happy dispositions. They get a *strong start* for a healthy childhood.

Designed for optimum nutrition of both full term and premature infants, Olac supplies milk protein in exceptionally generous amounts, to promote *sturdy growth*. Its fat is an easily digested, highly refined vegetable oil. Dextri-Maltose® supplements the lactose of the milk, to meet energy needs and spare protein for its essential tissue-building functions.

Convenient and simple to use, Olac feedings are prepared merely by adding water. A convenient special measure is enclosed in each can. One packed level measure of Olac to 2 ounces of water gives a formula supplying 20 calories per fluid ounce. Olac is valuable not only for bottle-fed infants but for supplementary and complementary feedings of breast-fed infants.

MEAD'S

Local Representative: Roger J. McElroy, 3181 McDonald Street, Coconut Grove 33, Florida, 4-4124.

MEAD JOHNSON & COMPANY
Evansville 21, Indiana, U. S. A.

The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXIX DECEMBER, 1952 No. 6

DEC 17 1952

IN THIS ISSUE

Management of An Outbreak of Anthrax
Scottie J. Wilson, Paul W. Hughes and Alfred E. Cronkite

Pernicious Anemia of Pregnancy
Herbert B. Lott and Curtis G. Rorebeck

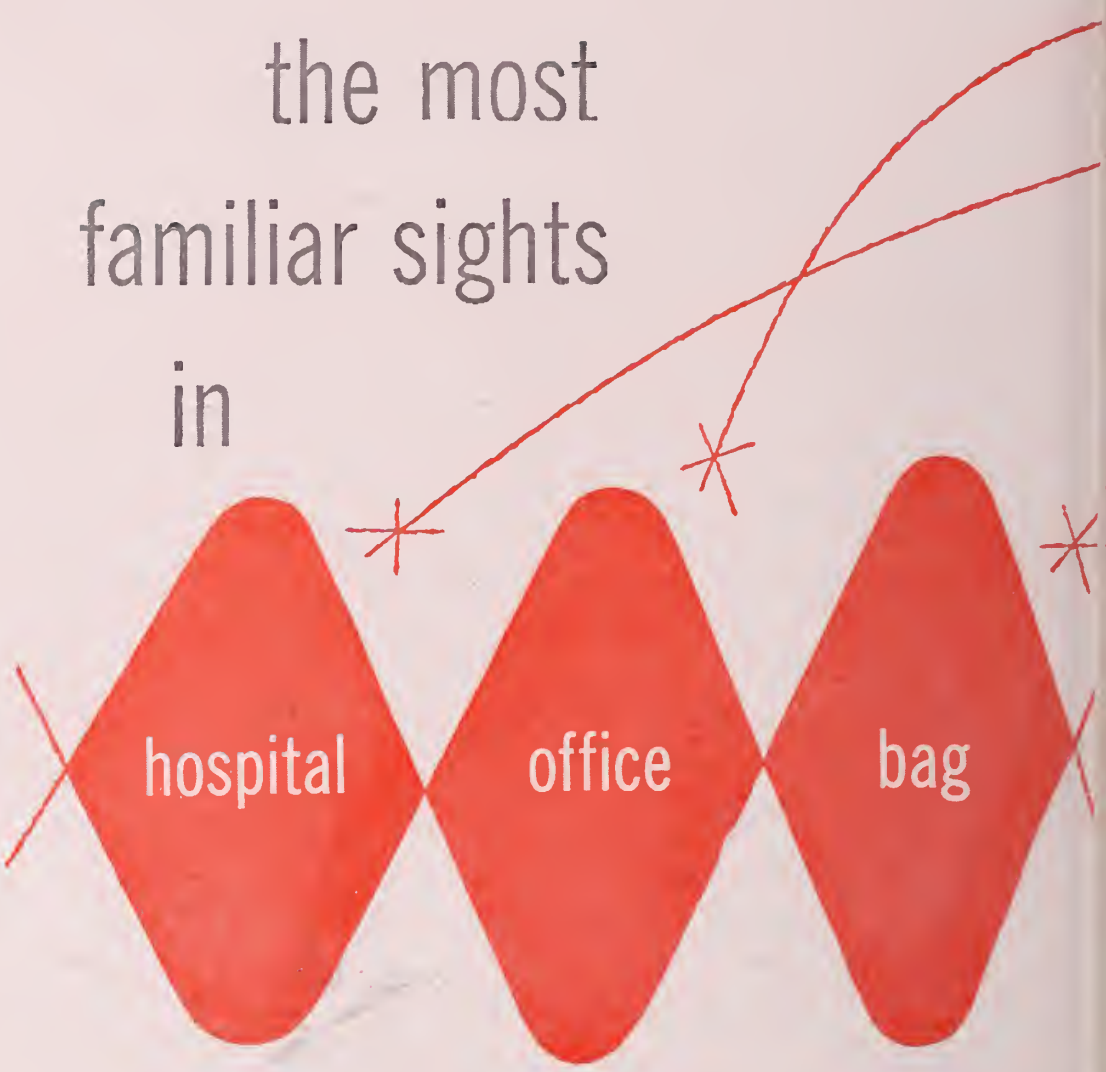
Low Salt Syndrome
George F. Schmitt, Jr.

Surgery of Parotid Tumors
Wilbur C. Sumner

Medical Men and Medical Events In British East Florida
An Editorial

OFFICIAL PUBLICATION OF THE FLORIDA MEDICAL ASSOCIATION

one of
the most
familiar sights
in



ADRENALIN®

ADRENALIN (epinephrine, Parke-Davis) is available as:

ADRENALIN CHLORIDE SOLUTION 1:1000
ADRENALIN CHLORIDE SOLUTION 1:100
ADRENALIN IN OIL 1:500

And in a variety of other forms to
meet medical and surgical requirements.

Introduced to the medical profession by the Parke-Davis Research Laboratories in 1901, ADRENALIN's notable versatility has made it one of the most widely used drugs in clinical practice. ADRENALIN is a standby for relieving asthmatic paroxysms, for treatment of protein shock, angioneurotic edema, cardiac arrest, and other medical or surgical emergencies. Among its many other important uses are: control of hemorrhage; prolongation of local anesthesia by delaying absorption; relaxation of uterine musculature; and reduction of intraocular pressure, vascular congestion and conjunctival edema.

MEDICAMENTA VERA

Parke, Davis & Company

DETROIT, MICHIGAN

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

Volume XXXIX DECEMBER, 1952 No. 6

CONTENTS

SCIENTIFIC ARTICLES

Management of an Outbreak of Anthrax, Scottie J. Wilson, M.D., Paul W. Hughes, M.D., and Alfred E. Cronkite, M.D. 403
Pernicious (Macrocytic) Anemia of Pregnancy, Herbert B. Lott, M.D., and Curtis G. Rorebeck, M.D. 407
The Low Salt Syndrome, George F. Schmitt, Jr., M.D. 411
Surgery of Parotid Tumors, Wilbur C. Sumner, M.D. 414
Cardioinhibitory Effects of Carotid Sinus Pressure, R. Judson Pearson, Jr., M.D., and John B. MacGregor, M.D. 416
Treatment of Ventricular Tachycardia, Report of a Resistant Case, William P. Logan, M.D. 422

ABSTRACTS OF MEDICAL ARTICLES

Drs. Raymond J. Fitzpatrick, Louis M. Orr, James B. Glanton, Joseph C. Hayward, Chester Cassel, Frank C. Bone, P. Scheinberg, M. Rich, M. S. Belle, J. G. Lyerly, Sidney Fox, Ralph Allen, J. Harold St. John, Morris Waisman, Arthur J. Butt, Barkley Beidleman, and John M. McDonald 426

EDITORIALS AND COMMENTARIES

Medical Men and Medical Events in British East Florida 433
Jingle Bells 441
Training in the Care of the Injured 441
Placement Assistance for Physicians 442
"How Sick Is Socialized Medicine?" 442
Midwinter Seminar in Ophthalmology and Otolaryngology, Miami Beach, Jan. 12-17, 1953 443
Graduate Medical Education 444
New Orleans Graduate Medical Assembly 444

GENERAL FEATURES

Officers and Committees 430
From Our President 432
Births and Deaths 444
Medical Officers Returned 444
New Members 444
State News Items 445
Wanted — For Sale 447
Component Society Notes 448
Woman's Auxiliary 450
Obituaries 452
Books Received 456
Schedule of Meetings 465
List of County Medical Societies, Presidents and Secretaries 466

This Journal is not responsible for the opinions and statements of its contributors.

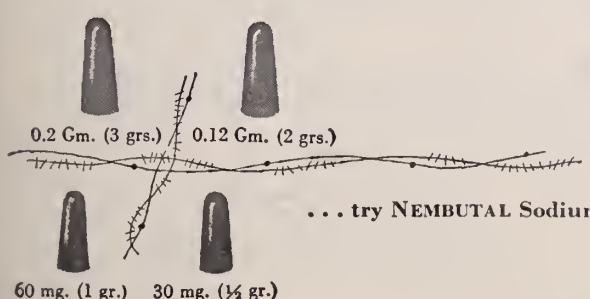
Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

YOU'D OPEN A PILE OF PRESENTS

from all the patients who represent the 44 uses for short-acting NEMBUTAL

. . . at least 44 of them—for 44 uses is the clinical record for short-acting NEMBUTAL. Adjusted doses of short-acting NEMBUTAL can achieve any desired degree of cerebral depression—from mild sedation to deep hypnosis. *And with only about half the dosage of many other barbiturates.* Smaller dosage means less drug to be inactivated, shorter duration of effect, wide margin of safety, and little tendency toward cumulative effect or barbiturate hangover. Remember: In equal oral doses, no other barbiturate combines *quicker, briefer, more profound effect* than NEMBUTAL. Abbott

For PROMPT SEDATION when the oral route is not feasible . . .

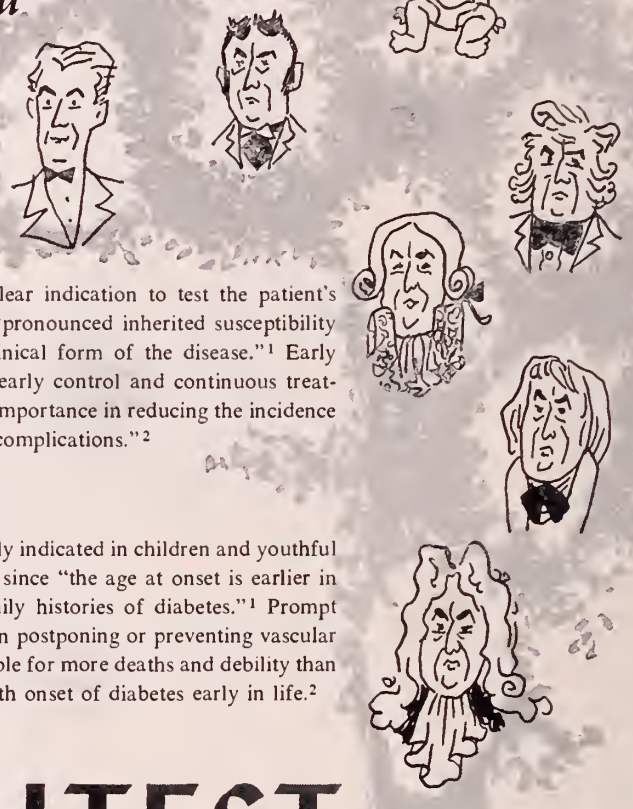


Nembutal®
(Pentobarbital, Abbott)

. . . try NEMBUTAL Sodium Suppositories

"diabetes mellitus

shows a marked familial tendency"[1]



the diabetic family

Every case of diabetes is a clear indication to test the patient's relatives for evidence of the "pronounced inherited susceptibility to the development of the clinical form of the disease."[1] Early diagnosis makes possible the early control and continuous treatment that are "of the greatest importance in reducing the incidence and severity of degenerative complications."[2]

diabetes in children

Testing for diabetes is especially indicated in children and youthful members of diabetic families, since "the age at onset is earlier in those cases with positive family histories of diabetes."[1] Prompt control is a significant factor in postponing or preventing vascular complications—now responsible for more deaths and debility than all other causes in patients with onset of diabetes early in life.[2]

CLINITEST

BRAND • REG. U.S. PAT. OFF.

for urine-sugar detection

Detection of urine-sugar is simple, reliable and rapid with *Clinitest* (Brand) Reagent Tablets. The results are directly read. No external heating is needed. *Clinitest* is excellent for office and clinic, and for diabetic patients.

1. Watson, E. M., and Thompson, M. W.: Am. J. Digest. Dis. *18*:326, 1951.

2. Wilson, J. L.; Root, H. F., and Marble, A.: J.A.M.A. *147*:1526 (Dec. 15) 1951

AMES COMPANY, INC. | ELKHART, INDIANA

Ames Company of Canada, Ltd., Toronto

C-3

YOUR KEY TO QUALITY

The keystone to the manufacture of all our products is the Production-Control and Research Laboratory. Here, periodic checks are made of every lot as it goes through the various production processes to insure against error and to guarantee the potency and the pharmaceutical elegance of the finished product. Every lot is carefully assayed before packaging or vialing.

YOUR KEY TO THE NEWEST AND LATEST IN DRUG THERAPIES

We have at our disposal one of the largest and finest groups of research facilities and chemists in the industry. In addition to our established line, you may expect new and improved prescription specialities in the near future which will be a welcome addition to your medical armametarium.

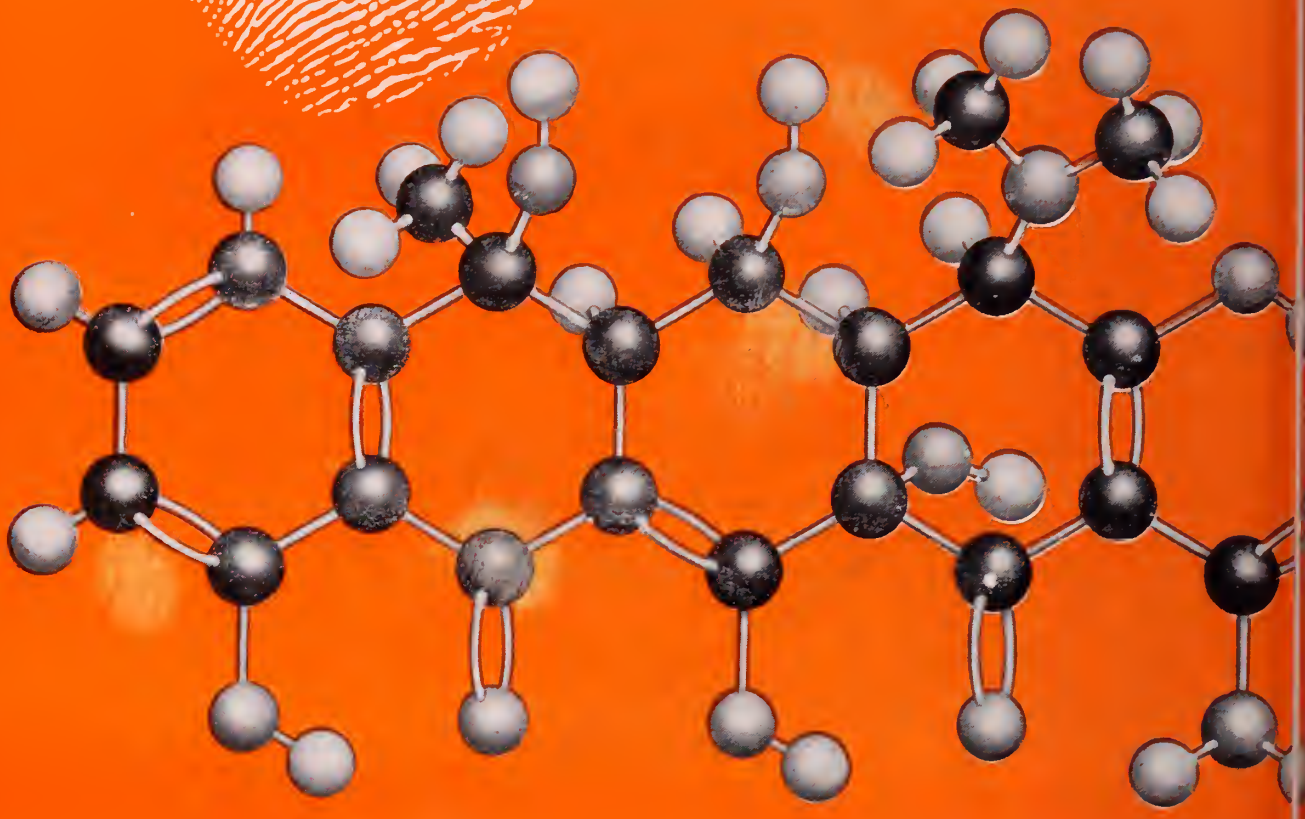
KEY CORPORATION

ETHICAL PHARMACEUTICALS

300 NORTH EAST 59th STREET
MIAMI, FLORIDA

FINEST QUALITY YET REASONABLY PRICED TO THE PATIENT

there is a difference...



ANTIBIOTIC DIVISION, CHAS. PFIZER & CO., INC., BROOKLYN 6, N. Y.

Pfizer

as shown by the recent discovery
of its molecular structure . . .

chemically unique

Terramycin

clinically unexcelled

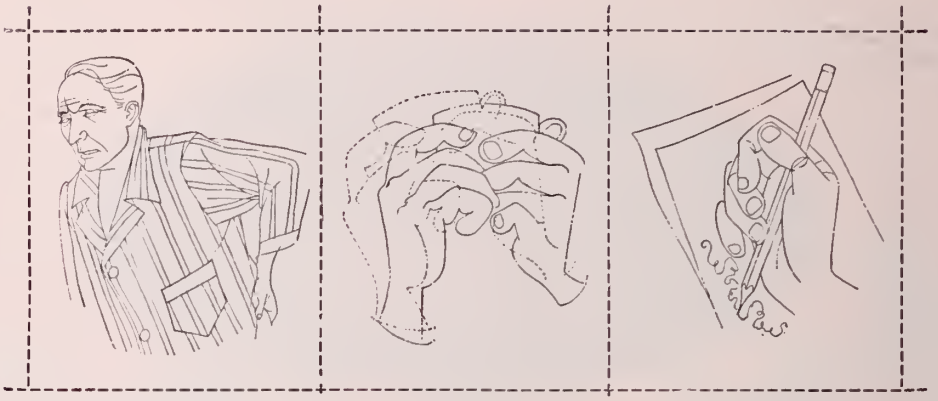
for toleration, effectiveness,
purity and potency

s largest producer of antibiotics

DON'T MISS

APPEARING REGULARLY IN THE J. A. M. A.

new uniform oral dosage



in muscle spasm of rheumatic disorders | **in acute alcoholism** | **in certain neurologic disorders**

The new, uniform oral dose for adults is 1-3 grams. This may be repeated 3-5 times per day.

The first dose prescribed should be at the lower end of the recommended dosage range *(an occasional patient may complain of side effects when* large *doses are given at the* start *of Tolserol therapy).* Subsequent doses may be adjusted to the needs of the individual patient. Whenever possible, Tolserol should be given after meals. When Tolserol is given between meals, it is desirable that the patient first drink ⅓ glass of milk or fruit juice.

Tolserol

Squibb Mephenesin

Tablets, 0.5 Gm. and 0.25 Gm., bottles of 100; *Capsules,* 0.25 Gm., bottles of 100; *Elixir,* 0.1 Gm. per cc., pint bottles; *Intravenous Solution,* 20 mg. per cc., 50 cc. and 100 cc. ampuls.

"TOLSEROL" (REG. U. S. PAT. OFF.) IS A TRADEMARK OF E. R. SQUIBB & SONS

SQUIBB

Depo *for duration*

Depo-Testosterone
CYCLOPENTYLPROPIONATE

is the new, slowly metabolized, oil-soluble ester of testosterone

Depo-Testosterone
CYCLOPENTYLPROPIONATE

exerts androgenic effect over longer periods of time than testosterone propionate

Depo-Testosterone
CYCLOPENTYLPROPIONATE

makes every injection a depo-like source of testosterone which maintains an active androgen level for at least 2 weeks

Depo-Testosterone
CYCLOPENTYLPROPIONATE

is latest in The Upjohn Company's series of Depo* preparations for prolonged drug action.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Each cc. contains:

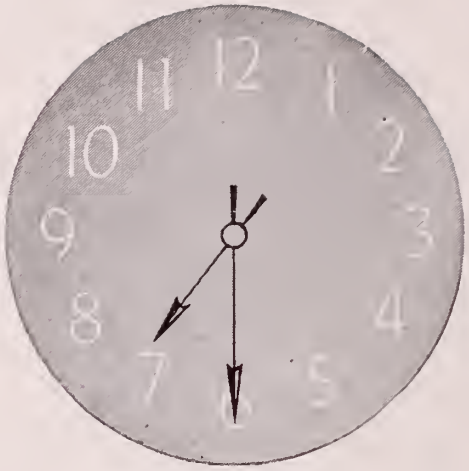
Testosterone Cyclopentylpropionate
50 or 100 mg.
Chlorobutanol (chloral derivative) in cottonseed oil
5 mg.

50 mg. size available in 10 cc. vials.
100 mg. size available in 1 cc. and 10 cc. vials.

**Trademark, Reg. U. S. Pat. Off.*

a product of **Upjohn Research** *for medicine . . . produced with care . . . designed for health*

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN



habit time

- Habit Time of Bowel Movement—not merely relief of constipation—is secured by proper use of Petrogalar.

Petrogalar promotes development of normally hydrated, comfortable and easily passed stools.

Once achieved, the normal bowel habit may often maintain itself even though the dosage of this adjuvant is slowly tapered off.

PETROGALAR®

AQUEOUS SUSPENSION OF MINERAL OIL, PLAIN

Supplied: Bottles of one pint

Wyeth®

Schering

CORTOGEN®

ACETATE

for

CORTISONE

therapy

CORTOGEN

The name Schering has come to stand for pioneering research and leadership in steroid hormone chemistry. Now Schering adds this new important product to its steroid line—available in ample amount to meet all your cortisone needs.

Available as 25 mg. tablets, bottles of 30. For complete information write to our Medical Service Department.

Schering CORPORATION · BLOOMFIELD, N. J.

PROVED effective in three years' clinical use

Cortone®

ACETATE
(CORTISONE ACETATE, MERCK)

Typical experience:

Administration of CORTONE,
systemically, reduced rheumatoid arthritis symptoms
in *all* of 100 patients treated.
Daily maintenance doses of 50 mg. or less, orally
were adequate in 53 per cent of cases.

Ward, E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.,
Proc. Staff Meet. Mayo Clin. 26: 361, Sept. 26, 1951.

CORTONE is the registered
trade-mark of Merck & Co., Inc.
for its brand of cortisone

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY
In Canada: MERCK & CO. Limited—Montreal

© Merck & Co. Inc.

"PREMARIN"®

Highly effective • Well tolerated • Imparts a feeling of well-being

"PREMARIN"

Most menopausal patients
experience striking relief
of symptoms with "Premarin."

"PREMARIN"

Estrogenic Substances (water-soluble)

"PREMARIN"

also known as Conjugated Estrogens (equine)

"PREMARIN"

5202 AYERST, McKENNA & HARRISON Limited • New York, N. Y. • Montreal, Canada

WHEN DIETARY SUPPLEMENTATION IS NEEDED...

what more could a supplement provide?

If the concept of an ideal dietary supplement could be formulated, it might well be one that provides qualitatively every substance of moment in human nutrition. It would provide those for which human daily needs are established as well as others which are considered of value, though their roles and quantitative requirements remain unknown.

How Ovaltine in milk approaches this concept, and how well the recommended three glassfuls daily augment the nutritional intake, is shown in the appended table. The two forms of Ovaltine available—plain and chocolate flavored—are closely alike in their nutrient values.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

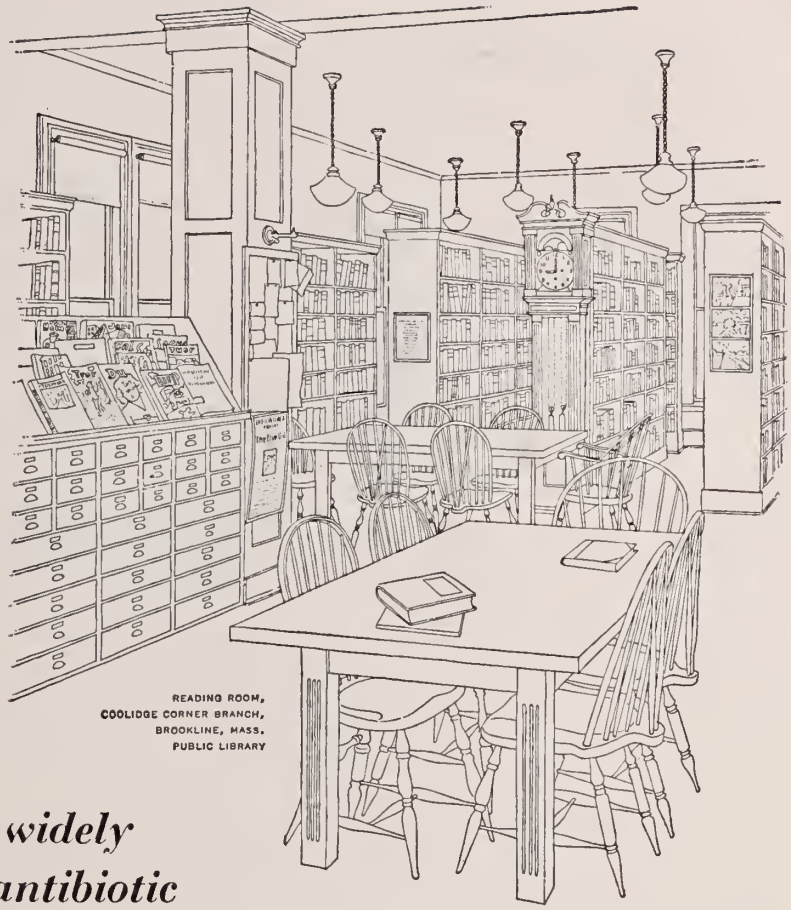
(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.7 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg	*VITAMIN D	420 I.U
ZINC	2.6 mg		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 m.
*FAT	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

New aureomycin minimal dosage for adults —four 250 mg. capsules daily, with milk.



READING ROOM,
COOLIDGE CORNER BRANCH,
BROOKLINE, MASS.
PUBLIC LIBRARY

a most widely accepted antibiotic in the broad-spectrum field is

AUREOMYCIN

Hydrochloride Crystalline

because

Physicians in the United States and throughout the world have recognized the time-saving value of immediate use of aureomycin in cases of active infection.

The successful use of aureomycin, as described in publications by physicians throughout the world, has increasingly encouraged others to use this antibiotic and publish reports thereon. To date, more than 7,000 original reports, editorials, brief comments, and similar notations have appeared in the published literature.

The trend of the literature clearly indicates that in desperate situations caused by infection, where previously cure would have proved difficult or impossible, aureomycin has saved the day.

Capsules: 50 mg.—Vials of 25 and 100. 100 mg.—Vials of 25 and bottles of 100. 250 mg.—Vials of 16 and bottles of 100.
Ophthalmic Solution: Vials of 25 mg.; solution prepared by adding 5 cc. distilled water.

LEDERLE LABORATORIES DIVISION *American Cyanamid Company* 30 Rockefeller Plaza, New York 20, N. Y.

"—either you bring my pop a new sphygmomanometer this Christmas, or he'll

call the MEDICAL SUPPLY MAN!"

There are probably a great many things you'd rather have for Christmas than a new sphyg, even if Santa could bring it to you! But Sonny's right, calling the Medical Supply Man IS the surest way to get the equipment, supplies and repairs you need.

The Medical Supply Company represents over 500 leading manufacturers of medical, hospital and laboratory equipment and supplies. In stock at all times are more than 15,000 individual items.

Even at Christmas time, when there's Santa to take care of many of your problems—for professional requirements it's still a good idea to

CALL THE MEDICAL SUPPLY MAN!

HOSPITAL, PHYSICIANS and LABORATORY SUPPLIES & EQUIPMENT

MEDICAL SUPPLY COMPANY

Essentials For Scientific Progress

MIAMI • of JACKSONVILLE • ORLANDO

230 N. E. THIRD ST.
MIAMI 32, FLA.

420 WEST MONROE ST.
JACKSONVILLE 2, FLA.

329 N. ORANGE AVE.
ORLANDO, FLA.

Doctor Harris has a night out...

Just as the plot thickens, some patient needs his immediate attention.

Dr. Harris occasionally attempts to get a little recreation, which all too often is abruptly halted.

Although by now he is fairly well used to the idea that hardly any of his time can be called his own, he does have a little more leisure than when he was younger. Because of improved techniques and better medicines, most of his patients are getting well faster and having fewer complications.

Even as the patient is vitally dependent on the physician, the development as well as the distribution of vital medicine is dependent on the pharmaceutical manufacturer. The following example shows the extent to which one company has gone to maintain . . .

Lilly

. . . quality in quantity

In order to broaden the sources of properly handled medicinal glands, Eli Lilly and Company launched an intensive educational campaign among the nation's packing houses. Armed with aprons, knives, slides, posters, and pamphlets, a corps of Lilly experts fanned out into every section of the country to demonstrate techniques of removal and storage. Within the first year of this program, they called on over 3,000 packers. An address was made by Lilly's medical research director to the assembled members of the American Meat Institute, who pledged their vigorous support. At their request, Eli Lilly and Company furnished this organization with slides, display material, and pertinent data which they use to further this program. One by one, new sources have developed, until now the nation's supply of suitably processed glands has reached an all-time high.

Lilly ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXIX Jacksonville, Florida, December, 1952 No. 6

Management of an Outbreak of Anthrax

Scottie J. Wilson, M.D.
Paul W. Hughes, M.D.
AND
Alfred E. Cronkite, M.D.
FORT LAUDERDALE

Part 1. — Anthrax

Scottie J. Wilson, M.D.

Anthrax is an acute infectious disease of herbivorous animals, especially cattle, hogs, sheep, goats and horses, caused by Bacillus anthracis, and transmissible to human beings, in whom it occurs in three forms, namely, cutaneous, pulmonary and intestinal.

This is the most widespread of all infections, geographically and zoologically. Continental Europe has the highest incidence. In the United States the disease occurs sporadically in the lower Mississippi Valley and in areas in Texas, Southern California, Missouri, Nebraska and South Dakota, infecting animals and farm laborers, shepherds, veterinarians, butchers, longshoremen and laboratory workers. In man, the most common method of infection is by direct inoculation of the skin, rarely by ingestion or through the respiratory tract. Direct transmission from human to human is rare. In animals anthrax is caused by ingestion. Incubation is one to five days, and the septicemic course of 12 to 72 hours, if the disease is untreated, has a mortality rate of 95 per cent. Dr. Hughes will tell about the spread of this disease, and Dr. Cronkite will discuss the bacteriologic and pathologic aspects.

Since spores may remain viable for 40 years, any contaminated area may become an endemic focus, indefinitely, for a possible outbreak of the disease in animals and humans. Physicians must ever be on the alert for anthrax.

Approximately 98 per cent of the cases occurring in the United States are of the cutaneous type. The lesion will be described later. Constitutional symptoms may include headache, malaise, subnormal to elevated temperature, and complete lack of apprehension to extreme anxiety. In all of our cases the patient showed some concern regarding the disease. As a rule, cutaneous anthrax pursues an uneventful course, terminating in death with septicemia or toxemia, sudden death probably due to bacillary occlusion of cerebral capillaries, or recovery. Effective antibiotic treatment of this disease dramatically changes the course, giving a favorable prognosis. The lesions heal more slowly than most infections of the skin.

Pulmonary anthrax produces few clinical signs. Cough is seldom severe. Difficult breathing, pressure on the chest, and accelerated breathing may be present. There is no visible lesion, and as a rule the patient feels well until a few hours before death, which usually occurs within 18 to 20 hours, but the patient may survive for five to 10 days. Prognosis is grave, if the disease is not treated early, because of the likelihood of septicemia and pulmonary destruction developing rapidly.

The rarest form of human anthrax is the gastrointestinal type. Symptoms include nausea, vomiting, diarrhea (often hemorrhagic), and severe abdominal pain and tenderness. This form occurs as a result of the ingestion of anthrax bacilli or as a secondary manifestation of the cutaneous or pulmonary type of the disease. Prognosis is grave, if it is not treated early, because of the rapid development of septicemia and shock from hemorrhagic enteritis and destructive changes.

Apparently most of the antibiotics are effective in the treatment of all forms of this disease, namely, sulfadiazine, penicillin, aureomycin, chloromycetin and terramycin. Management of the outbreak of anthrax in Broward County did not permit establishing any plan for treatment of cases

Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 28, 1952.

for the purpose of comparing the effectiveness of various antibiotics. All of our patients received penicillin, and some were given other drugs mentioned. In some cases, penicillin or mycin drugs were also applied topically to the lesions. All lesions were purposely treated with simple sterile gauze covering of the skin areas involved, with no attempt to disturb the injured skin and subcutaneous tissues. The patients were placed at bed rest, and the skin lesions were left absolutely alone, except as described.

Five cases of cutaneous anthrax were treated in this outbreak. Those affected included 2 veterinarians, 1 laboratory technician, 1 cowhand and 1 child whose mother nursed a veterinarian. In all cases the disease resulted from infected abrasions of the hand or arm. In 1 case there was secondary involvement of the leg. One exposure was in the laboratory, one from a remote source, and three from contact with infected animals. All of the patients suffered mild to moderately severe constitutional symptoms. Three had taken penicillin three to four days before a physician saw them. All had temperature above 100 F. and in all but 2 leukocytosis was present. Stool, sputum and blood cultures were negative. Response to antibiotics was dramatic in 3 cases. All patients recovered.

Part 2. — Outbreak in Florida

Paul W. Hughes, M.D.

During the first week in October 1951, a cowhand was noted to have skin lesions unusual in character. A consulting physician made the diagnosis of cutaneous anthrax, which was soon substantiated by laboratory tests.

The cowhand had handled a number of dead cattle on a neighboring ranch. During the previous 30 days approximately 100 cattle had died at this ranch, presumably of anaplasmosis. After the diagnosis of anthrax was made on the cowhand, the last cow he handled was checked. On autopsy and after laboratory tests, it was established that this cow died of anthrax.

In the meantime, 22 live cattle from this infected herd had been sent to two slaughter houses in Broward and Hendry counties. The Broward County Health Department in conjunction with the State Livestock Sanitary Board immediately took steps to have the hides of these slaughtered animals incinerated and the carcasses sent to the soap vat.

Knowing that the anthrax spore would survive in the soil for years, authorities immediately took strenuous quarantine measures and declared a five mile area of quarantine about the infected ranch. Quarantine regulations forbid movement of animals, sod, soil or vehicles out of these pasture lands. All humans entering the premises had to take special "boot" precautions so as not to "track out" anthrax spores.

In the meantime, a thorough investigation of the source of this anthrax outbreak was made. Supplementary cattle feed practically always contains steamed bone meal. There is a history of the substitution of raw bone meal for steamed bone meal in the supplementary feed given to the infected cattle as there presumably was a momentary shortage of the steamed bone meal. This most likely mode of infection, nevertheless, was never confirmed. It seems the most likely method of infection as there had been no anthrax in the entire county of Broward for at least the past 26 years. No cattle had come into the county in recent months from known anthrax areas. It is curious also that Florida was one of the eight states where anthrax broke out simultaneously. The pattern of the outbreak was a spotted one, implying the mode of transmission to be one by such a material as a single infected sample of raw bone meal. Immediate check of all fertilizers and supplementary feeds containing any kind of bone meal gave negative results throughout the county.

The resulting spread of the disease to other parts of the county was largely accounted for by transfer of cattle and equipment in the county.

Whenever a cow died, an autopsy was performed by a veterinarian. Blood and spleen swabs were collected in small bottles and sent to the local laboratory for a gram stain. In that way a quick presumptive diagnosis could be made and the animal accordingly incinerated on the spot with quicklime subsequently placed on the ashes. It was impossible to bury cattle as the water table was high.

Quick consideration was given not only to prevent spread of anthrax to the 30,000 cattle but also to Broward County's 100,000 human inhabitants. Much of the meat and milk from this area also was marketed in the adjoining county of Dade with 500,000 inhabitants.

In addition to the methods mentioned, buzzards and biting insects, prevalent in great numbers, provided another method of spreading the disease. Also, some cattle had died in two feet of water, thus allowing the anthrax spores to be distributed via the high water table.

A shortage of vaccine handicapped the start of the program. Infected herds were given first priority. Dairy herds in the quarantine area were second in priority. The "buffer" zones about each infected ranch were third in consideration. Finally, all cattle in the 225 square mile area not in these priorities were immunized.

It was emphasized at a mass meeting of cattlemen that every animal dying must be autopsied by a veterinarian so that complete information as to the spread of the disease and the effectiveness of the vaccine would be known at all times.

Because there were 5 proved human skin cases and 12 suspicious cases, the attention of the public and of physicians was brought to bear on unusual skin lesions.

It is not believed at this writing that the anthrax outbreak is by any means ended. Human skin cases will be a possibility in the future months and even years in this area of concern.

One important observation came about in our investigations. It seems that neither the federal nor the state governments have any systematic anthrax inspection system of bone meal, raw or steamed, which is either distributed in or imported into the United States.

Part 3. — Bacteriologic and Pathologic Aspects

Alfred E. Cronkite, M.D.

The bacteriology of anthrax is of great historic interest. It was with this disease that Davaine, Rayer, Pollender, Pasteur and Koch made observations which were essentially the beginning of scientific medical bacteriology. Koch in 1876 established his famous postulates upon the basis of his studies of Bacillus anthracis.

The disease anthrax is caused by B. anthracis, a large, capsulated, nonmotile, sporulating, aerobic rod, which may occur singly or as short chains in tissues and as long chains in cultures. It is ordinarily described as gram-positive, but in practice much variability is noted, particularly in early lesions and in young cultures. While the classic description is that the ends of the rods are square, and such is often the case, rounded ends are also seen. Growth on ordinary media is rapid, producing within 18 hours flat colonies irregular in shape with a grayish white "ground glass" appearance. The edge of the colony examined under low magnification may show a "hair-lock" appearance due to parallel strands of chains of bacilli.

Regardless of how typical any particular organism may seem to be morphologically and culturally, animal virulence tests should be performed before one concludes that it is B. anthracis. Because of the public health aspects and the seriousness of the disease, in a suspected case of anthrax the patient should be isolated and treated as if the diagnosis were established, but because of the economic and psychologic problems involved, definite diagnosis should be withheld until animal inoculations have been reported. Mice, guinea pigs and rabbits are susceptible to B. anthracis; rats are resistant.

Mice should be inoculated subcutaneously or intravenously with tissue or exudate from the suspected lesions or with culture material if the initial specimen is inadequate. Virulent anthrax bacilli will ordinarily kill mice within 36 to 72 hours after inoculation. A smear from the enlarged spleen of such animals will contain numerous typical organisms.

While the various members of the Bacillus subtilis group may be confused morphologically with B. anthracis and may be differentiated and classified by careful prolonged cultural studies, this procedure is of academic interest. In practice, the determination of virulence is the crucial point and may be performed by any competent pathologist or bacteriologist with the necessary animals and facilities.

Anthrax in the human is most frequently of the cutaneous type, the so-called "malignant pustule." It starts as a reddish macule, which develops into a papule and thence into a vesicle within a relatively short period. The lesion may become hemorrhagic and finally develops a tough central eschar with surrounding erythema, edema and lymphangitis. The local lesion is relatively painless, though regional lymph nodes may be tender. Lebowich, McKillip and Conboy have made a study of cutaneous anthrax with clinical correlation. Histologically, the cutaneous lesions are characterized by a severe acute serohemorrhagic inflammatory process with multiple irregular areas of coagulation necrosis, swarming with bacilli. The epithelium is generally intact but edematous, elevated by underlying edema and markedly infiltrated by neutrophilic granulocytes. The corium shows a severe hemorrhagic infiltrate with intense interstitial edema, which extends beyond the zone infiltrated by bacilli. Generally there is extensive diffuse granulocytic infiltrate without abscess formation extending through the underlying subcutaneous tissue. The exudate contains mainly erythrocytes and neutrophilic granulocytes as well as a few macrophages.

One interesting feature is that there seems to be a complete absence of phagocytosis of encapsulated bacilli and no agglutination of bacilli. Lymphatics and the smaller blood vessels are dilated; there are ordinarily no thrombi nor bacilli in them.

Slides of cultures were provided through the courtesy of Dr. Murray Sanders of the University of Miami; those of tissue sections by the U. S. Armed Forces Institute of Pathology.

References

Doig, A. T., and Gemmill, J. S.: Epidemiology of a Small Outbreak of Anthrax, Lancet 1:1011-1012 (May 5) 1951.

Duhos, René J., editor: Bacterial and Mycotic Infections of Man [Aided by a Grant from the National Foundation for Infantile Paralysis, Inc.], Philadelphia, J. B. Lippincott Company, 1948.

Ellingston, H. V.; Kadull, P. J.; Bookwalter, H. L., and Howe, C.: Cutaneous Anthrax, Report of 25 Cases, J. A. M. A. 131:1105-1108 (Aug. 3) 1946.

Gold, H., and Boger, W. P.: Newer Antibiotics in the Treatment of Anthrax, New England J. Med. 244:391-394 (March 15) 1951.

Koch, R.: Die Aetiologie der Milzbrand-Krankheit, begründet auf die Entwicklungsgeschichte des Bacillus anthracis, Beitr. Z. Biol. d. Pflanzen 2:277-310, 1877.

Lebowich, R. J.; McKillip, B. G., and Conboy, J. R.: Cutaneous Anthrax; Pathologic Study with Clinical Correlation, Am. J. Clin. Path. 13: 505-515 (Oct.) 1943.

Sanders, M.; Wilson, S. J.; Hughes, P., and Cronkite, A. E.: Anthrax, Bulletin of the Dade County Medical Association 23:42-46 (March) 1952.

Shanahan, R. H.; Griffin, J. R., and von Auersperg, A. P.: Anthrax Meningitis; Report of Case of Internal Anthrax with Recovery, Am. J. Clin. Path. 17:719-722 (Sept.) 1947.

Smith, W. V., D.V.M.: A Review of the Literature on Anthrax, Florida State Board of Health, 1951.

Stein, C. D.: Studies and Observations on Laboratory Diagnosis of Anthrax, Vet. Med. 38:130-139 (April) 1943.

Tabershaw, I. R., and Morris, G. E.: Epidemiologic Aspects of Anthrax in Massachusetts, New England J. Med. 228:92-93 (Jan. 21) 1943.

309 Blount Building.

Discussion

DR. JOHN R. HEGE, JR., Hollywood: I am presenting the history of one of the more complicated cases that occurred in this particular epidemic. In the 5½ year old son of a nurse attending a patient with anthrax there developed a skin lesion of the right elbow. About the same time the boy sprained his left ankle. Forty-eight hours later, there followed an elevation of temperature to 106 F., pain in the lateral lower portion of the fibula and subcutaneous white hot edema from mid foot to mid thigh without adenitis or lymphangitis.

The previously discussed antibiotics brought the usual resolution of lesions although a spiking fever with only moderate general malaise lasted for nine days. Since that time there has been a slowly progressive profuse and painless periosteal involvement of most of the entire left fibula. Test withdrawals of the antibiotics resulted in definite but local clinical and bacteriologic relapses, necessitating continuous antibiotic treatment for a three months' period on large doses — a million units of penicillin daily and a thousand milligrams of chloromycetin (the antibiotics to which this particular child's organisms were most sensitive). Because of possible antagonism between the chloromycetin and penicillin, the chloromycetin was stopped for two days early in the course, but was followed by an immediate rise of the temperature to 106 F. again. On resumption of both penicillin and chloromycetin, the child once more improved remarkably. He has now been asymptomatic for the past five months. The case is presented as an illustration of one of the perhaps many rare complications that might be met during an anthrax epidemic.

Incidentally, before showing the slides I should state that the child had had chicken pox about three months previously, and some of the secondary infection lesions had persisted. This slide shows the small area in which the original lesion developed. Note the black eschar in the center and the whitish edema surrounding it. This lesion was somewhat painful; no adenitis nor lymphangitis was present in the arm. This picture, which shows the lesion on the leg, was taken on about the fifth day of the illness, and much of the whitish edema had subsided. The wrinkling of the skin perhaps is still evident in this area. At the present time the whitish edema is in the area of the circumference indicated. Also, a reddish edema developed around that, which was not painful. The child's pain was in this area. Material obtained from the elbow and by stab culture in the edematous area of the leg yielded positive cultures. The organism was sensitive to penicillin and chloromycetin and insensitive to terramycin, aureomycin, streptomycin and bacitracin. This second slide gives a view of the lesion in the leg which is more nearly straight. Some of the whitish edema persisted for perhaps a month, and each time the antibiotics were stopped, it would immediately come back without any constitutional symptoms. This roentgenogram was taken two months ago.

DR. GRETCHEN V. SQUIRES, Pensacola: I should like to ask one question which possibly Dr. Cronkite can answer. How soon after the initial dose of antibiotic do the cultures become negative? We have had only 1 case that was clinically classic for the skin lesions. The patient had had 300,000 units of penicillin, and the blister was completely negative as far as organisms in the blood smears indicated, and blood cultures after about 48 hours, which was when I left to come down here, were still negative. How much interference do you have in your cultural diagnoses with that initial shot of penicillin given before the patient comes into the laboratory?

DR. CRONKITE: The answer in brief is, "I do not know." As far as I recall, most of the patients, when the disease was diagnosed, had already had some kind of "sulfa" or antibiotic treatment and, if I am not mistaken, the veterinarians who were performing autopsies on these cattle had penicillin as their main item of diet for most of the period of this outbreak, and we were still able to grow the organisms in their lesions. Of course that is not unusual in that they were cutaneous lesions which we were culturing.

We did not run any scientifically controlled studies whatever. We were more or less on the firing line trying to make a diagnosis with everybody at us with "Is it, or ain't it?" And we, not having any animal facilities of our own, were in turn dependent upon the laboratory of the State Board of Health in Jacksonville for the animal inoculations. Between the time it took to mail specimens up there and for them sometimes to reculture them and inoculate animals, there was some delay, but that is about all I have to say about that particular problem.

The first case may be slightly interesting. The patient came in on a Friday morning, and I did not have the courage of my convictions to tell anybody that the gram-negative large rod which I saw looked to me like the pictures I remembered of anthrax. I had never seen the disease. I never expected to. But when we cultured the specimen the next day and got a negative culture, we were ready to forget it. About that time, however, one of the veterinarians came in with a cow spleen and said he was worried. After I looked at the smear, I was worried, too, and there was no doubt in my mind then that probably the cutaneous lesion that I had seen the day before, despite the negative culture, was undoubtedly anthrax. It was another couple of days before we were able to prove it. And then of course every skin lesion of every patient who came to anybody in the county was suspected of being anthrax. We were culturing right and left, and all we were doing was trying to make an initial diagnosis. There were no true follow-up studies bacteriologically.

DR. WILSON, concluding: I might add one word that I think would be comforting to everybody, and that is that Dr. Cronkite was so right about the hysteria that might go on when one suspects a case of anthrax. That is entirely unnecessary because this is a disease that is easily treated and responds well to antibiotic therapy.

The case presented here, I think, would be a most unusual and difficult one and was managed well. I should like to congratulate Dr. Hege.

In Dr. Hege's case there was a positive culture one month after the original onset of the disease. Also, in the Journal of the American Medical Association of Aug. 3, 1946, Ellingston and his associates stated that in only 3 of 25 cases were viable Bacillus anthracis organisms recovered from lesions after 24 hours' treatment with penicillin, 1 to 4 million, and sulfadiazine. That is an interesting statement. In addition, I might point out that Shanahan and his associates reported in the American Journal of Clinical Pathology, September 1947, a 5 per cent incidence of meningeal involvement with the cutaneous anthrax. Many of those cases, however, were not treated as early as our cases, and they became complicated systemically.

Also, I might briefly make another statement for emphasis, namely, that anthrax is a problem in South Florida but not one to cause hysteria. It may extend to other areas of the state, and it is especially expected to reappear, if it does, during the wet season when the spores may change to organisms like you saw so that humans and animals both can acquire the disease.

Relative to what might be the best antibiotic, I do not believe one can make a flat statement. Certainly from a practical standpoint, penicillin might well be the one of choice. It is cheap, it is easy to give, and most of the cases of anthrax reported throughout the literature respond to penicillin. In my opinion, however, the sensitivity test definitely should be done. If one wants to start with penicillin and one of the sulfonamides, a triple sulfonamide or sulfadiazine, and then have the sensitivity test made, that probably would be the procedure of choice. The results of sensitivity tests on these organisms, reported to me by Dr. Hughes, as determined by the State Board of Health laboratory in Jacksonville — I believe these were organisms, however, chiefly as tested in animals — were penicillin, moderately sensitive, — this is most confusing — dihydrostreptomycin, very sensitive, aureomycin, very sensitive, chloromycetin, moderately sensitive, terramycin, very sensitive, neomycin, very sensitive, sulfadiazine, resistant. So I think probably the organism per individual case has its own degree of sensitivity, and if I were to treat a case again, I believe I would start off giving penicillin and sulfadiazine and perform the sensitivity test for that individual case.

Pernicious (Macrocytic) Anemia of Pregnancy

Herbert B. Lott, M.D.
and
Curtis G. Rorebeck, M.D.
Tampa

Pernicious anemia of pregnancy was first described in scientific literature over a century ago by Channing,[1] who reported 10 cases, all of which were fatal. Since this presentation there have been numerous small series and isolated cases reported in the literature. All case reports have been practically the same with a mortality rate of 50 to 75 per cent before the use of blood transfusion therapy. Since this therapy was introduced, the mortality rate has been steadily reduced.

Pernicious anemia of pregnancy was first differentiated from true Addison's pernicious anemia by Osler in 1919.[2] He pointed out that pernicious anemia of pregnancy often ends spontaneously by complete recovery, whereas true Addison's anemia is characterized by exacerbations and remissions regardless of therapy.

The onset of this anemia in the pregnant patient is insidious, but the course is often dramatic. In a period of two to four weeks, a woman may regress from a state of apparent normalcy to that of a dangerously ill patient. She is apt to arrive at a severe stage of anemia in spite of adequate intake of iron. A drop in red blood cells from 4.5 million to less than 1.0 million, with a less precipitous drop in hemoglobin, is not unusual. This rapid deterioration in an apparently normal patient usually finds the attending physician busily increasing the patient's iron intake, on the assumption he is dealing with a stubborn iron deficiency anemia. By the time the progressive and severe anemia so alarms the physician that complete blood and bone marrow studies are made, he is dealing with a seriously ill patient.

Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 28, 1952.

Differential Diagnosis

The peripheral blood picture in pernicious anemia of pregnancy is variable, in some cases following closely that seen in true pernicious anemia. The bone marrow picture, however, is identical in both, indicating an arrested maturation of the megaloblast. This last is perhaps the immediate cause of these anemias.

According to Wintrobe,[3] the onset in the reported cases of pernicious anemia of pregnancy occurred in the third trimester. The principal symptoms and signs of the disease, once established, are definite, and in all cases it seems to follow closely the same course. Much like Addison's anemia, the disease makes its approach in

an insidious manner, but unlike Addison's pernicious anemia, it makes rapid progress. True, the patient rarely will be able to give the exact date of onset of fatigue and weakness, but these are always her first complaint. The lemon yellow pallor that is characteristic in Addison's pernicious anemia rarely occurs in pernicious anemia of pregnancy; instead, there is more often the pallor of any severe secondary anemia of pregnancy. The sore tongue, so prevalent in true pernicious anemia, may be absent in pernicious anemia of pregnancy. Gastric disturbances such as nausea, diarrhea and anorexia, which occur frequently in Addison's anemia, rarely are disturbing factors in pernicious anemia of pregnancy. When present, these are much less severe.

Petechiae are not as characteristic as in true pernicious anemia, and therefore are of little diagnostic value. Fever may occur, but this is probably a result of secondary infection, which is so common in any severe anemia, rather than a result of the disease. There may or may not be changes in the sclera, but often in the severe cases, as in Addison's anemia, there are pronounced retinal hemorrhages. Hemorrhages occurring in the mucous membrane of other parts of the body are not uncommon. There is always a decided increase in pulse rate, and this varies proportionately with the progress of the disease. Hemic murmurs are as a rule present and increase with the severity of the anemia. The spleen and liver may be slightly enlarged. Neurologic symptoms are rare.

The principal diagnostic features that differentiate pernicious anemia of pregnancy from true Addison's pernicious anemia are:

1. The usual presence of free hydrochloric acid in gastric juices, with or without histamine injections.
2. A low frequency of macrocytosis and anisocytosis in the peripheral blood.
3. The rapidly progressive course of the disease.
4. A slow response to liver and B_{12} therapy.
5. The absence of neurologic signs and symptoms.
6. The failure of the disease to return after delivery, and a complete remission even though all therapy has been discontinued.

Etiology

The etiology of the disease has not been determined. It is believed that there is a dietary factor involved, as it is comparatively rare in the well nourished person and is commonest in the undernourished. Its prevalence in India bears out this contention. Fever is common, and in a certain number of cases infection or toxemia appears to be the precipitating etiologic agent.

Therapy

Therapy in the past, as is attested by the previously mentioned high mortality, was disappointing. A response similar to that of true pernicious anemia to crude liver, or liver concentrates, was not often observed in pernicious anemia of pregnancy. The advent of blood transfusions was a life-saving procedure, and with the discovery of the effects of folic acid, a satisfactory mode of therapy was afforded. The severe anemia can now be immediately overcome by one or more transfusions of whole blood, and a complete remission brought about by the use of 10 to 20 mg. of folic acid daily.

One case is presented as follows:

Report of Case

A 28 year old white gravida three, para one, abortus one, was first seen on March 6, 1951, her last menstrual period having been January 18. The past history was noncontributory except for the previous pregnancies, a review of which is of interest. The first pregnancy was apparently uncomplicated, except for nausea and excessive gain in weight, until admission to the hospital in August 1948 for delivery. The hemoglobin estimation at that time was 4.4 Gm. per hundred cubic centimeters of blood (30 per cent). Following delivery of a normal male infant weighing 7 pounds, 14 ounces, she had prolonged postpartum uterine bleeding and was given three 500 cc. transfusions of whole blood. She remained nervous and in poor general health for about one year afterward.

The second pregnancy was terminated in November 1949, by hysterotomy, three months following intrauterine fetal death from unknown causes at 4½ months' gestation. The reason for abdominal delivery remains obscure. At the time of admission to the hospital for delivery, she was anemic with a hemoglobin estimation of about 4.4 Gm. (30 per cent). It was necessary to give her four transfusions before and after delivery. The postpartum course was normal.

The initial physical findings in this pregnancy were entirely normal, including an apparently normal intrauterine pregnancy of about six weeks' duration. Laboratory studies were not significant except for a hemoglobin estimation of 98 per cent. The Rh factor was negative, but no sensitization was present.

The course of this pregnancy was complicated on April 20 by an appendectomy performed for acute suppurative appendicitis while the patient was in Tallahassee. The red blood cell count at that time was 3.11 million, and the hemoglobin estimation was 10.5 Gm. (67 per cent). It was otherwise uneventful until July 27, at which time the patient complained of general fatigue, loss of appetite and dizziness. Because of increased pallor, the iron intake was doubled and injections of crude liver, 1 cc. twice weekly, were begun. The patient was again seen on July 30, at which time there was great increase in fatigue, dizziness and general malaise. The crude liver was increased to 1 cc. daily. She was next seen on August 8, obviously acutely ill. She complained of severe weakness, palpitation, dizziness, tingling in all extremities, blurred vision, nausea and vomiting, and pain in the back. The temperature was 100.6 F.

At this time she was sent to a private clinical laboratory for an immediate blood count. The report of the pathologist[4] was as follows:

"Red blood cells 1.06 million; hemoglobin 3.9 Gm. (27 per cent); white blood cells 2,100; color index 1.2; differential count, segmented forms 47, unsegmented forms 12, metamyelocytes 4, total polymorphonuclears 63, myelocytes 3, lymphocytes 31, basophils 1, eosinophils 2, and nuclear index 3. The red blood cells show great anisocytosis and poikilocytosis. Many of the cells are macrocytes, but microcytes are also present. Two nucleated red blood cells are present per hundred white blood cells, one of which is a megaloblast. The platelets are somewhat decreased. Although many of the polymorphonuclears are multinucleated, there is a considerable shift to the left in the granular cells. The anemia is that of a macrocytic hyperchromic type. A bone marrow study is indicated in order to determine the etiology of this anemia and for proper therapy."

As soon as the blood count was completed, the pathologist[4] requested the patient be sent back to the laboratory for a sternal puncture and for further peripheral blood studies. The bone marrow and further peripheral blood studies were completed. The pathologist[4] reported the marrow as follows:

"Segmented forms 3; unsegmented forms 10; metamyelocytes 11; myelocytes 11; premyelocytes 2; megaloblasts with scattered erythroblasts 50; lymphocytes 8; eosinophils 2; reticulum cells 1.

"This is an extremely hyperplastic marrow showing a large number of early or basophilic megaloblasts as well as later megaloblasts and normoblasts. The granular cells, too, are increased and show numerous giant metamyelocytes. Megakaryocytes are scattered throughout. Aplastic and myelophthisic anemias are ruled out by the sternal marrow examination.

"We believe this to be an example of the rare condition of a true pernicious anemia of pregnancy. The following observations support this diagnosis:

"1. The blood picture is that of a macrocytic hyperchromic anemia, but it is not typical of classical pernicious anemia. The red blood cells are not as large nor as hyperchromic as those seen in true pernicious anemia with this degree of anemia. In addition, the shift to the left in the granular cells only takes place in complicated true pernicious anemia, but it does occur in pernicious anemia of pregnancy.

"2. The bone marrow is megaloblastic and contains giant metamyelocytes.

"3. The relative refractoriness of this patient to liver therapy which has been given parenterally over a period of weeks.

"4. The history of a severe anemia during the last trimester of the previous full term pregnancy and disappearance of the anemia following delivery.

"5. The onset of the present anemia during the last trimester of pregnancy.

"6. The presence of free hydrochloric acid in the gastric juice.

"Recommended Treatment:

" 1. The transfusions of red blood cells only as necessary to maintain a satisfactory hemoglobin concentration compatible with the well-being of the mother and the infant in utero. Cells are indicated here rather than whole blood since the latter will further increase the plasma volume, which is as a rule increased in this stage of pregnancy.

" 2. The administration of folic acid, 10 to 30 mg. daily by mouth.

" 3. The administration of liver by mouth.

" The peripheral blood showed a 1 per cent reticulocyte count, and the icterus index was 6.5 per cent. Clot retraction was complete in one hour, and the clot was firm."

Urinalysis on admission to the hospital revealed 3 plus albumin, with white blood cells packed and in clumps. There were many red blood cells present, and it was thought that the patient had an acute pyelonephritis complicating the anemia.

Physical findings revealed an acutely ill patient in the seventh month of gestation. In spite of a temperature of 102 F., there was a definite pallor of the skin over the entire body. The pulse was rapid but strong, and the blood pressure was normal. The liver was palpable 4 cm. below the right costal margin and slightly tender; the spleen was not palpable. There was 2 plus pitting pretibial edema. At the costovertebral angle, tenderness was present bilaterally. Retinoscopy revealed many fresh flame-shaped hemorrhages in both fundi.

A gastric analysis on August 9 revealed: quantity, 120 cc.; free hydrochloric acid, 7 degrees; total hydrochloric acid, 32 degrees.

The patient was given 500 cc. of whole blood on August 8, and 500 cc. of whole blood and 500 cc. of packed red cells on August 9. Administration of penicillin, 300,000 units daily, was begun, and on August 10 folic acid therapy was started, 20 mg. twice daily.

The patient was seen in consultation on August 13 by an ophthalmologist.[5] His findings will be given in the discussion.

The patient improved rapidly and was discharged six days after admission clinically much improved. A red blood cell count on August 14 revealed 2.4 million red cells with hemoglobin 7.4 Gm. (51 per cent), and a reticulocyte response of 10 per cent. Following discharge from the hospital, the patient was given folic acid, 20 mg. twice daily, with continued improvement in the red blood cell count and hemoglobin. Clinically, she appeared normal. On August 23 the red blood cell count was 3.04 million and the hemoglobin 8.7 Gm. (60 per cent). By August 30 the red blood cell count had reached 3.33 million and the hemoglobin 10 Gm. (64 per cent).

She was readmitted on October 14, ten days prior to the expected date of labor for elective section. At this time the red blood cell count was 3.72 million, and the hemoglobin estimation was 10.6 Gm. (73 per cent). Temperature, pulse and blood pressure were normal, the urine was clear, and the fundi were normal. A low cervical cesarean section was performed and a normal infant delivered. The patient was given 500 cc. of whole blood during the procedure although the blood loss was not excessive. She was discharged on October 20 in good condition.

Since delivery, the patient has moved to Alaska and from there reports she is well. The last red blood cell count, received March 26, 1952, revealed a hemoglobin estimation of 13.7 Gm. (94 per cent) and 4.63 million red blood cells.

Summary

A typical case of pernicious anemia of pregnancy is reported. The history indicates that the patient perhaps had had attacks with each of the earlier pregnancies, though there is no definite proof. There was no evidence of any response to liver and iron therapy in this case, but the rapid response to transfusion and continued response to folic acid therapy were as would be expected. After delivery and with all therapy discontinued, the patient had a normal postpartum convalescence.

1104 Citizens Building.

We acknowledge with appreciation the valuable assistance rendered by Dr. James N. Patterson in the preparation of this paper.

References

1. Channing, W.: Notes on Anhaemia, Principally in its Connections with the Puerperal State, and with Functional Disease of the Uterus; with Cases, New England Quart. F. 1:157, 1842.
2. Osler, W.: Severe Anaemias of Pregnancy and Postpartum State, Brit. M. J. 1:1 (Jan. 4) 1919.
3. Wintrobe, M. M.: Clinical Hematology, ed. 3, Philadelphia, Lea & Febiger, 1951, p. 479.
4. Personal communication from Dr. James N. Patterson, Tampa.
5. Personal communication from Dr. Sherman B. Forbes, Tampa.

Discussion

DR. MILLARD B. WHITE, Sarasota: First, I should like to compliment the essayist on the excellent presentation of this paper concerning the diagnosis and management of so-called pernicious anemia of pregnancy. Although rare, this disease seems to be an entity. Certainly it may be a dramatic complication of pregnancy. The points related to the differential diagnosis from both the etiologic and the clinical aspects have been well presented. It is evident, however, that the hematologic findings in cases of pernicious anemia of pregnancy are so variable that its differentiation from the other members of the pernicious anemia family may be most difficult. The occurrence of a rapidly developing macrocytic anemia in pregnancy should lead the clinician to entertain such a diagnosis and institute the proper therapy.

Hematologically, there are two observations not stressed or omitted that may be helpful in the differentiation of pernicious anemia of pregnancy from primary pernicious anemia. In true pernicious anemia there is a shift both to the right and the left of the hemogram, giving a wide base when plotted as a Price-Jones curve, whereas in the majority of cases of pernicious anemia of pregnancy the shift is primarily to the left, as indicated by the increase in the percentage of immature polymorphonuclears. The bone marrow in the untreated case of pernicious anemia of pregnancy shows a megaloblastic hyperplasia and also an associated normoblastic hyperplasia. This type of myelogram is identical with that found in primary pernicious anemia after two to three days of adequate treatment.

Clinically, it has become increasingly evident that folic acid is the substance of choice in the treatment of this disease state. Yet little is actually known in regard to its mode of action in the restoration of normal maturation and delivery of the erythroid elements to the peripheral circulation. It is hoped that the application of such technics as bone marrow culture and a fuller investigation of the role of mucroproteins in the transport of the intrinsic factor will throw some light on the action of folic acid and vitamin B_{12} in macrocytic anemia.

I should like to point out the importance of a thorough investigation of all anemias in regard to their etiology. Such investigation should be carried out before therapy is instituted, since treatment, even though it may be totally inadequate, may alter the blood picture and make hematologic classification most difficult.

DR. SHERMAN B. FORBES, Tampa: In this most interesting and unusual case, which has been so well presented by Dr. Lott, read by Dr. Rorebeck and discussed by Dr. White, the patient was first seen by me on Aug. 13, 1951, during hospitalization. Her main ocular complaint was inability to see at a distance and absolute inability to read.

The external ocular examination was not spectacular, but there was definite pallor of the conjunctiva, both bulbar and palpebral, with some attenuation of the vessels. The funduscopic picture, however, was most interesting. There was diffuse pallor of the retina with attenuated vessels and some pallor of the disk. Between the nerve head and the macula in the right eye there were the largest striate retinal hemorrhages that I have ever observed. In addition, there was a large hemorrhage in the macula and perimacular region that certainly in my estimation was partly preretinal, probably having broken through the internal limiting membrane. In the left eye, the striate bleedings were in the same area between the nerve head and the macula and also to the nasal side of the disk. Above the striate bleedings to the temporal side there was a large area of bleeding, in the center of which was apparently an exudative whitish area. The area of macular bleeding was of lesser size and apparently of thickness also than in the right eye. Verifying my opinion that the bleedings in the macular region had broken through the internal limiting membrane, there were blood cells in the posterior vitreous, highly discrete but there.

The diagrams of the funduscopic picture which I now present were made at the bedside, as no camera was available in the hospital. The vision was 20/400 in each eye with good peripheral fields and central scotoma for form and color. The patient was unable to read a Jaeger 20 with either eye.

Ten days later, on August 23, the vision was 20/100 and 20/200 in the right and left eye, respectively. There was great improvement in the fundal pathologic picture as is illustrated by these photographs. The patient was now much improved. The attenuation of the vessels and pallor of the retina are not apparent because, as Dr. Rorebeck has pointed out, the results of the transfusion and the folic acid therapy were spectacular.

On August 30, a week later, the distance vision was 20/40 and 20/50 in the right and left eye, respectively. The fundi were essentially normal. The only defect in the fields was a pericentral scotoma of a highly discrete nature in the left eye. In two more weeks the ocular picture was essentially normal in all respects.

A review of the literature reveals a paucity of reports in which specific reference was made to ophthalmic observations. Lindeboom (Gynaecologia 123:175-185, March 1947) reported 1 case of pernicious anemia of pregnancy in which retinal bleedings occurred and stated that hemorrhages more often appear in the retina than in the skin. In his review of the subject of pernicious anemia in pregnancy, Callender (Quart. J. Med. 13:75-105, April-July, 1944) declared that "retinal hemorrhages have been found in nearly half of those patients in whom an ophthalmoscopic examination has been made" and cited Miller and Studdert (Lancet 2:332-334, Sept. 19, 1942) and Stevenson (Edinburgh M. J. 45, July 1938) in support of this statement. In 10 of the 21 cases in which ophthalmic findings were noted in their series of 23 cases, Miller and Studdert observed retinal bleedings. Stevenson mentioned the occurrence of retinal hemorrhages in 12 of the 22 cases in his series. Rendelstein (Wien. med. Wchnschr. 101:517-518, 1951) included among the less important differential diagnostic symptoms the occurrence of retinal hemorrhages ("Netzhautblutungen") in true pernicious anemia. Singularly enough, all these references to ophthalmic observations in pernicious anemia of pregnancy occurred in the European literature.

Discussing such a case casts the ophthalmologist in an odd role, but I assure you that I have enjoyed the privilege. I think Dr. Lott and Dr. Rorebeck, also Dr. White and the pathologist, Dr. Patterson, have added something to our knowledge of the subject.

Seventy-Ninth Annual Convention
Florida Medical Association
Hollywood, April 26-29, 1953

The Low Salt Syndrome

George F. Schmitt, Jr., M.D.
MIAMI

During the last decade, emphasis has been placed on disencumbering the body of excess sodium in the treatment of the failing heart. Vigorously prosecuted regimens have led to a condition lately called by Schroeder[1] the low salt syndrome. It has not been generally recognized that we physicians are now fabricating therapeutically disturbances in the electrolyte balance that previously occurred only in grave maladies.[2,3] The dangers of sodium depletion have long been recognized and combated forcibly, but it has only been in recent years that Holley and McLester,[4] Holley,[5] MacGuire,[6] Soloff and Zatuchni[7] and others[8] have exposed that the pendulum of the manner of handling has oscillated too far toward overtreatment rather pursuing a point equidistant between that and criminal procrastination. The time has come to reassess our mode of medical care of the stumbling wellspring of our existence.

Mechanism

The physical laws governing osmosis direct the phenomena in this condition.

Body water is separated into intracellular and extracellular compartments. The extracellular compartment is subdivided into the interstitial and circulating portions. Water enters and leaves a section depending upon the concentration of electrolytes in that sphere. The chief cation of the cell is potassium; that of the media surrounding is sodium. While some shifts of water do occur when potassium is excreted or retained, the shifts are minor when compared to the changes that take place when sodium is acquired or dissipated. When sodium is lost either in certain pathologic conditions or under the duress of a mercurial diuretic, there is more of a riddance of the ion than of water. The body fluids become hypotonic. The kidneys, in an effort to maintain isotonicity, excrete more water, and the extracellular water level falls.

Because of the osmotic pressure induced by the proteins and the hydrostatic pressure, there is less penury in the vascular situation than in the intracellular region. If the process continues, however, the circulating blood slows in its constant rounds in the body, the arterial blood pressure is lowered, the renal blood flow is abated, and anuria occurs. Thereafter, when water is introduced, the extracellular cistern does not have sufficient ionic magnetism to retain it. The water then enters the cell, which has a higher osmotic pressure, and water intoxication takes place. This explains the gain in weight in patients enduring this condition. The display is further complicated by nitrogen retention brought about by the lessening of the renal blood flow in addition to the efforts of the body to sustain proper osmotic balance among the dissident forces.

Causes

The only mode of entrance of sodium into the body is through the gastrointestinal tract. Disturbance in the intake or the output of the ion in the alimentary system will immediately reflect itself in the water compartments of the body. A normal daily diet contains between 6 and 8 Gm. of salt. A fare containing much less rapidly depletes sodium stores. Although sodium is approximately 98 per cent absorbed, occasionally there is insufficient time to extract the metal as it passes through the tube. The diarrheas of ulcerative colitis or cholera, and the constant loss of vital fluid in ileostomies and colostomies may seriously exhaust the sodium stocks of the body.

Of all the organs, the kidney excretes the greatest amount of sodium. To a great extent, the adrenocortical hormone directs its excretion. The symptoms of Addison's disease are comparable to those of the low salt syndrome.[9] Patients with chronic glomerulonephritis may demonstrate

Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 28, 1952.

early signs of salt deficiency.[3,10] During the salvage phase of lower nephron nephrosis, when the tubular cells are regenerating, they are not as sensitive to the salt-retaining hormone. Consequently, there is a loss of electrolytes.

A frequent provoker of the low salt syndrome is the overenthusiastic use of the mercurial diuretics. They transiently paralyze the tubular epithelium with a sequential loss of electrolytes and water. With the advent of new and improved diuretics, we can expect bigger and better salt depletion syndromes.

There are other less frequent excitants. Severe sweating that occurs in the tropics or in the boiler room of ships (stoker's syndrome) has long been thwarted with salt tablets. The repeated removal of fluid from serous cavities exhausts the supply of sodium. The injudicious use of wrongly selected parenteral fluids may so dilute the body juices that the result is indistinguishable from the low salt constellation of symptoms.

Symptomatology and Diagnosis

Because the low salt syndrome may develop insidiously, it is important to be on the lookout for the signs that presage the onset of hyponatremia. Schroeder[1] has summarized the symptomatology as follows: (1) Drowsiness, weakness and lethargy; (2) loss of appetite; (3) thirst; (4) nausea and vomiting; (5) abdominal and muscular cramps; (6) successive depression of urinary volume for three to five days; (7) depression of the urinary chlorides to negligible quantities; (8) rapid gain in weight; (9) elevation of the nonprotein nitrogen of the blood; (10) fall in the plasma levels of sodium; (11) tachycardia. In the aged, the onset is more readily produced. Often, it is extremely difficult to ascertain whether one is dealing with the low salt syndrome, excessive sedation, progression of cardiac failure, overdigitalization, thromboembolic phenomena, or unrelated infection.

The principal aid in diagnosis is the determination of some of the components of the body fluids. Because the reporting of the constituents in milligrams does not accurately express the acid and base potentialities of the ions, the preferred method is to signify the concentration in milliequivalents. A milliequivalent is a unit of measure of the comparative weights of different compounds, elements, or groups of ions that possess the same chemical value. It is derived as follows:

$$\text{mEq/l} = \frac{\text{mg/l}}{\text{atomic weight}} \times \text{valence}$$

The use of conversion factors obviates the necessity for using the formula. It is only necessary to multiply the value in milligrams by the appropriate factor. For the cations, it is calcium 0.5; potassium 0.257; magnesium 0.833, and sodium 0.435. For the anions, it is chlorides, 0.286; bicarbonates, 0.455; phosphates, 0.58; and sulfates, 0.625.

The constitution of the total base in milliequivalents is sodium 142, potassium 5, calcium 5, and magnesium 3. The values assigned to the acid components are chlorides 103, bicarbonate 28, phosphate 2, protein 16, sulfates and organic ions 6. From these figures, it is obvious that the determination of the chlorides alone does not truly reflect the quantity of sodium, but by adding 12 milliequivalents to the sum of the chlorides and the bicarbonates, the resultant approximately equals the sodium content of the blood. The flame photometer determines directly the level of the blood sodium, but is costly and requires a long interval to warm up.

For the day to day following of the patient, the determination of the urinary chlorides can be of some aid. Bryant, Iob, Phillips and Blecha[11] modified Fantus' method.[12] The reagents required are a 10 per cent solution of potassium chromate and 0.73 per cent solution of silver nitrate. The procedure is simple. "Place 10 drops of urine in a Kahn tube. Add one drop of potassium chromate, and shake mixture. Add the silver nitrate mixture drop by drop, shaking the mixture between each addition until a permanent light brown or brick red color appears. Each drop of silver nitrate represents 250 milligrams of chloride or 100 milligrams of sodium per liter." When chlorides disappear from the urine, the physician must be most cautious in prescribing rigid low sodium diets or forcing mercurial diuretics. The test is reasonably correct; in many cases the consumption of salt substitutes or drugs rich in chlorides, such as ammonium chloride, will negate the results. The test is to be used merely as a guide. Some authors[8] have reported failures with it.

Treatment

The fundamental fact to be kept in mind is that therapy is directed at increasing the amount of sodium — not water — in the body. The use of fluids of any kind further dilutes those in the intracellular space, and must be kept at a minimum. The best method is to give salt tablets by mouth, but all too frequently, vomiting ensues. The preferred system is to give 5 per cent sodium chloride solution slowly intravenously. Citron, Bercu, Lemmer and Massie[13] pointed out that the dose can be estimated from the body weight and the plasma sodium concentration determined directly or indirectly. The difference between the patient's plasma sodium concentration and the normal (142 mEq/l) multiplied by the total body water (53 per cent of the body weight) equals the total sodium deficit in milliequivalents. One hundred cubic centimeters of 5 per cent saline contains 86 mEq/l of sodium. By appropriate calculations, an accurate appraisal of the amount of sodium chloride solution required may be ascertained.

Summary

Salt depletion regimens are not as innocuous as supposed.

The common causes of sodium depletion are deficient intake; loss of salt from the gastrointestinal tract, skin and kidneys; removal of fluid from serous cavities; adrenocortical insufficiency; and inappropriate fluid replacement therapy.

The chief symptoms are drowsiness, weakness, lethargy, abdominal cramps, thirst, nausea and vomiting. The signs are depression of urinary volume, rapid progressive gain in weight, elevation of nonprotein nitrogen, fall in plasma chloride and sodium, and tachycardia.

The best treatment is 5 per cent sodium chloride intravenously.

References

1. Schroeder, H. A.: Renal Failure Associated with Low Extracellular Sodium Chloride; Low Salt Syndrome, J. A. M. A. 141:117-124 (Sept. 10) 1949.
2. Holley, H. L., and McLester, J. S.: Salt Depletion Syndrome Associated with Decompensated Cirrhosis of the Liver, J. A. M. A. 145:392-393 (Feb. 10) 1951.
3. McLester, J. S.: Influence of Rigid Salt Restriction in Diet of Chronic Nephritis, Am. J. M. Sc. 163:794-796 (June) 1922.
4. Holley, H. L., and McLester, J. S.: Renal Failure in Patients Treated with Salt Free Diets, J. M. A. Alabama 21:9-11 (July) 1951.
5. Holley, H. L.: The Salt Depletion Syndrome, South. M. J. 45:153-160 (Feb.) 1952.
6. MacGuire, W. B., Jr.: Risk of Uremia Due to Sodium Depletion, J. A. M. A. 137:1377-1378 (Aug. 14) 1948.
7. Soloff, L. A., and Zatuchni, J.: Syndrome of Salt Depletion Induced by a Regimen of Sodium Restriction and Sodium Diuresis, J. A. M. A. 139:1136-1139 (April 23) 1949.
8. Randall, H. T.; Habif, D. V., and Lockwood, J. S.: Sodium Deficiency in Surgical Patients and Failure of Urine Chloride as a Guide to Parenteral Therapy, Surgery 28:182-208 (Aug.) 1950.
9. Poll, D., and Stern, J. E.: Untoward Effects of Diuresis, with Special Reference to Mercurial Diuretics, Arch. Int. Med. 58:1087-1094 (Dec.) 1936.
10. Thorn, G. W.; Koepf, G. F., and Clinton, M., Jr.: Renal Failure Simulating Adrenocortical Insufficiency, New England J. Med. 231:76-85 (July 20) 1944.
11. Bryant, J. M.; Job, V.; Phillips, G. L., and Blecha, E. E.: Estimation of Urinary Sodium; A Simple Test for Patients on Low Sodium Diets, J. A. M. A. 140:670-672 (June 25) 1949.
12. Fantus, B.: Fluid Postoperatively; Statistical Study, J. A. M. A. 107:14-17 (July 4) 1936.
13. Citron, D.; Bercu, B.; Lemmer, R., and Massie, E.: Congestive Heart Failure and Hyponatremia; Untoward Effects of Mercurial Diuresis, Ann. Int. Med. 34:872-880 (April) 1951.

Additional References

Burch, G.: Disturbances of Water and Sodium Balance in Congestive Heart Failure, Mod. Concepts Cardiovas. Dis. 17:(N.P.) May, 1948.

Eskwith, I. S.: The Use of Sodium in the Management of Chronic Congestive Failure, New York State J. Med. 51:1305-1308 (May) 1951.

Futcher, P. H., and Schroeder, H. A.: Studies on Congestive Heart Failure: Impaired Renal Excretion of Sodium Chloride, Am. J. M. Sc. 204:52-62 (July) 1942.

Jaffe, H. L.; Master, A. M., and Dorrance, W.: Salt Depletion Syndrome Following Mercurial Diuresis in Elderly Persons, Am. J. M. Sc. 220:60-65 (July) 1950.

Newburgh, L. H., and Reimer, A.: Rationale and Administration of Low-Sodium Diet, J. Am. Dietet. A. 23:1047-1051 (Dec.) 1947.

Peters, J. P.: Diagnostic Significance of Electrolyte Disturbances, Bull. New York Acad. Med. 25:749-763 (Dec.) 1949.

Peters, J. P.: Sodium, Water and Edema, J. Mt. Sinai Hosp. 17:159-175 (Sept.-Oct.) 1950.

Relman, A. S., and Schwartz, W. B.: The Recognition and Management of Sodium Depletion, M. Clin. North America 35:1533-1542 (Sept.) 1951.

Schroeder, H. A.: Studies on Congestive Heart Failure; Importance of Restriction of Salt as Compared to Water, Am. Heart J. 22:141-153 (Aug.) 1941.

Wiggins, W. S.; Manry, C. H.; Lyons, R. H., and Pitts, R. F.: The Effect of Salt Loading and Salt Depletion on Renal Function and Electrolyte Excretion in Man, Circulation 3:275-281 (Feb.) 1951.

30 Southeast Eighth Street.

Discussion

Dr. Jere W. Annis, Lakeland: Dr. Schmitt has emphasized that the low salt syndrome is not new, but, because of its being therapeutically induced in recent years, it has been brought more forcefully to the attention of physicians. It is extremely important that one be constantly on the alert for it.

The new fervor in prescribing mercurial diuretics with precise restriction of the sodium content of the diet is to be condemned. It is better to dehydrate the patient somewhat more slowly rather than constantly to seek to reduce the par for the course.

I cannot stress too much the desirability of reporting the electrolytes in terms of milliequivalents instead of milligrams. The use of conversion factors obviates the necessity of using the formula. It is only necessary to multiply the value in milligrams by the appropriate factor.

The desirability of having Bryant's solutions, particularly in areas without elaborate laboratory facilities, cannot be overemphasized. When chlorides disappear from the urine, it behooves the physician to be extremely cautious.

After the physician has corrected the pathologic physiologic processes by the judicious use of sodium, he must be extremely careful not to precipitate an episode of cardiac failure by overzealously prescribing sodium.

All in all, the management of heart failure and its complications is difficult. It is certainly not as easy as a number of authors would lead one to believe.

Surgery of Parotid Tumors

WILBUR C. SUMNER, M.D.
JACKSONVILLE

The high incidence of recurrence of apparently benign mixed tumors, even after long periods of time, the large number of cases of complete or partial nerve injury and the frequency of and poor outlook in cases with malignant lesions of salivary gland origin make this subject one of extreme importance to all of us in the practice of medicine. In this paper I shall not attempt to cover the entire field of problems that one encounters in the diagnosis and treatment of tumors of the salivary gland. In fact, I shall limit the discussion for the most part to the so-called mixed salivary gland tumors of the parotid. Other tumors will be discussed only if they have a direct correlation to the subject, either in the type of treatment or diagnosis. The problems that face us as surgeons in these cases are mainly those of therapy. The clinical diagnosis of the run-of-the-mill mixed salivary gland tumors is usually easy; not that the clinical diagnosis is always upheld by the histologic diagnosis. The problems are not those of local limitations. We have at our disposal all the necessary paraphernalia for accurate and accepted therapy.

Clinically, these tumors are discrete and located in areas where salivary gland tissue is present, either the four major glands or the minor ones within the oral cavity. Of the major glands, the parotid is the commonest site. Although there is no definite age limit, the middle age group is most frequently affected. The tumors vary in size from 1 to 2 cm. to several centimeters, varying with the length of time of growth. In the series of 21 cases reported here, the largest was 10 by 15 cm. These tumors are painless, and for this reason patients may carry them for a long time before seeking medical attention. They tend to grow slowly and, due to the anatomic structure of the area, they grow outward. The benign types do not involve the skin and are deceiving as to depth, a fact which can often be misleading as to the seriousness of removal. Those who do recognize the seriousness and have had experience with injury to the facial nerve are prone to adopt the waiting and watching attitude.

As a surgeon, when I read the pathologic description of these tumors with the various classifications that are set up, I tend to become confused. Unfortunately, the confusion is not entirely relieved when they are discussed with the pathologist. This seems to be a more or less universal opinion and one that requires complete understanding between the surgeon and the pathologist. Unless this exists, too frequently serious mistakes in judgment can be made as to the type of treatment to be performed.

Classification

For better understanding of the problems under discussion, I present a simple classification which does not take into consideration the various histologic pictures described by certain pathologists, and no attempt is made to discuss in any way the theories as to the formation of these tumors. (1) Mixed salivary gland tumors mean to me a benign tumor that does not metastasize, but has the potentiality of recurring locally if not entirely removed. (2) Malignant mixed salivary gland tumors which have the potentiality of metastasis as well as recurrence locally. (3) Wharton's tumor, which is a cystic type benign tumor occurring in the parotid region. (4) Carcinoma of the salivary gland, both adenocarinoma and epidermoid types.

Surgical Procedures

The major technical problem in parotid surgery is the preservation of the seventh nerve. The major oncologic problem is the correlation of the histologic picture of the tumor with the ultimate prognosis. As far as the treatment of the mixed salivary gland tumor is concerned, I believe that surgery offers the best chance of cure. In the discussion of what type of surgery should be performed, the factors of the seventh nerve and the pathologic nature of the tumor help decide the surgical procedure. I believe that the seventh

Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 28, 1952.

nerve should always be preserved in the treatment of benign salivary gland tumors if at all possible. It can be successfully preserved in the majority of cases. It should be stated here that the usual textbook on anatomy describes the nerve as spreading out in the substance of the parotid gland. Recent anatomic research shows that this is not true. The parotid is divided into two lobes, the superior and the inferior, being connected by an isthmus. The nerve enters the operative area below the gland, and the main division surrounds the isthmus and then divides into the respective branches. Thus the nerve is likened to the filler of a sandwich.

In order to preserve the facial nerve, it must be exposed. There are several different maneuvers used by different surgeons in identifying and preserving the seventh nerve. Technically for me this is simpler if the main trunk is first identified as it leaves the stylohyoid foramen. Once the main trunk is identified, the division and branches can be dissected out as necessary in order adequately to remove the tumor. The other approach to the seventh nerve is using a branch as the first section to be identified and then dissecting back to the main trunk. Each surgeon should use the procedure that he is most familiar with and according to the size of the tumor. I believe, however, that there is more chance of cutting or severely traumatizing branches of the nerve, or cutting into the so-called capsule of the tumor, by the latter approach, if used routinely.

Regardless of what approach to the nerve is being used, the first step is to have an adequate incision so placed as to give good exposure of the operative area and to be cosmetically satisfactory. After adequate skin flaps and hemostasis have been secured, the parotid gland is pulled forward, and dissection is carried down to the styloid process. By blunt dissection, the main trunk of the seventh nerve can be identified in this area. After identification is made, the divisions of the nerve are identified, and then the dissection proceeds adequately to remove as much of the gland as necessary.

Many believe that more than a simple enucleation of the mixed salivary gland tumor is advisable. Certainly a portion of the surrounding gland should be removed, and in a large number of cases either a complete lobectomy or total parotidectomy should be performed, but with preservation of the function of the seventh nerve even if a tedious dissection has to be made to separate the tumor from the nerve. At times, branches of the facial nerve may have to be sacrificed in order adequately to remove the tumor, but after the nerve is completely dissected out, removal can be effected without causing paralysis as the distal portion has frequent anastomosis. Many surgeons prefer the use of a stimulating current to identify branches of the nerve, and certainly if a branch of the facial nerve is to be the first portion exposed, the stimuator is of great value.

The reasons for advising more than simple enucleation are: (1) There is no real capsule. The so-called capsule shows mixed tumor cells, and if any of these are left in, a recurrence is probable. Tumors which are grossly adequately enucleated still often show microscopic evidence of mixed tumor cells in the bed as sections are taken. (2) There is evidence of mixed tumors arising in more than one focus within a local area of the gland. (3) If there are early malignant changes within the tumor, a lobectomy or total parotidectomy might well be all that is necessary. By following these steps, I believe that many problems of these tumors of the parotid gland can be made easier.

In those tumors which clinically are not believed to be simple mixed salivary gland tumors, or those that are obviously malignant, a more radical type of surgery is advisable. Around 60 per cent of these tumors that are malignant remain, or metastasize locally; the remainder show distant metastasis. With these figures in mind, I believe that early radical surgery, if necessary sacrificing the seventh nerve with complete neck dissection, should be performed. In cases in which this is not advisable, roentgen ray irradiation does have considerable value. It also can be utilized for those cases in which a lobectomy or total parotidectomy has been performed with later diagnosis of malignant mixed salivary gland tumor being reported.

Summary

I should like to emphasize that tumors of the parotid gland should be removed early. In their removal, certainly in the majority of cases, in order to preserve the function of the seventh nerve, the nerve should be exposed and more than a simple enucleation of the tumor performed. The high percentage of malignant changes occurring in this and other series of cases would indicate that a delay in removal of these tumors could be hazardous.

In my series of 21 cases, malignant changes were present in 23.8 per cent. The average age

of the patients with malignant lesions was 63.6 years, the youngest patient being 51 years of age. In the 76.2 per cent of the cases in which the tumor was benign, the average age of the patients was 43.4 years. Eleven of the patients were women, and 10 were men. In 19 per cent of the cases the lesion was recurrent when the patient was first seen. The benign tumors were classified as ordinary mixed 17, cystoma 1, Worthin's 1, inflammatory mass 1, undetermined 1. Since in this series the longest period of postoperative observation is only five years, statistics on the follow-up of the cases are not presented.

I wish to make a plea for adequate excision of these tumors at the first attempt as recurrences are frequent and repeated surgery often, even with tedious dissection, results in facial paralysis.

References

Brown, J. B.; McDowell, F., and Fryer, M. P.: Direct Operative Removal of Benign Mixed Tumors of Anlage Origin in Parotid Region, with Summary of Parotid Tumors in General, Surg., Gynec. & Obst. 90:257-268 (March) 1950.
Howard, J. M., and others: Parotid Tumors in Children, Surg., Gynec. & Obst. 90:307-319 (March) 1950.
Jones, C. S.; Scarborough, J. E., and Brown, R. L.: Tumors of the Parotid Glands; Review of 57 Cases, J. M. A. Georgia 38:530-533 (Dec.) 1949.
McCune, W. S.: Total Parotidectomy in Tumors of the Parotid Gland, Arch. Surg. 62:715-723 (May) 1951.
McFarland, J.: Mysterious Mixed Tumors of Salivary Glands, Surg., Gynec. & Obst. 76:23-34 (Jan.) 1943.
State, D.: Superficial Lobectomy and Total Parotidectomy with Preservation of Facial Nerve in Treatment of Parotid Tumors, Surg., Gynec. & Obst. 89:237-241 (Aug.) 1949.
Stevenson, G. F., and Hazard, J. B.: Papillary Cystadenoma Lymphomatosum; A Review and Report of 8 Cases, Cleveland Clin. Quart. 18:85-92 (April) 1951.
Taylor, G. W., and Garcelon, G. G.: Tumors of Salivary-Gland Origin, New England J. Med. 238:766-768 (May 27) 1948.

238 West Church Street.

Discussion

DR. C. FRANK CHUNN, Tampa: The presentation by Dr. Sumner was precise and to the point in two respects, adequate resection of parotid tumors and, if at all possible, sparing of the facial nerve. It should be emphasized that the anatomy of the parotid gland is different from what many of us were taught in that it is a bilobed gland connected in the center by a small isthmus. Around this isthmus is the beginning of the branching of the facial nerve.

As to exposure of the nerve in resection of small benign tumors of the superficial lobe, we have chosen not to expose the nerve but to resect these tumors from the superficial lobe. In tumors of questionable malignancy or large tumors, however, we believe that it certainly has been to our advantage to expose the main trunk of the nerve before it enters the gland and to preserve all of the branches if possible. We have not hesitated to section the mandibular branch of the nerve where even benign tumors involved it. The superior branches we have maintained if at all possible. I certainly agree with Dr. Sumner that more than enucleation should be done, that even in the benign mixed tumors as wide an area as possible of normal gland tissue around the tumor should be resected with the tumor.

One other technical step that will help in the resection of the tumor and in visualizing and sparing the nerve is first to ligate the external maxillary artery in the neck and have a comparatively dry field in which to proceed with the operation. I have enjoyed this paper and fully approve of the two stressed points of wide resection and preservation of the nerve if possible.

Cardioinhibitory Effects of Carotid Sinus Pressure

R. JUDSON PEARSON, JR., M.D.
COMMANDER, MEDICAL CORPS, UNITED STATES NAVY
AND
JOHN B. MACGREGOR, M.D.
COMMANDER, MEDICAL CORPS, UNITED STATES NAVY
JACKSONVILLE

Since Weiss and Baker[1] first delineated the three types of carotid sinus response, increasing evidence has accumulated to suggest that hyperactivity of the cardioinhibitory carotid sinus reflex indicates myocardial disease.[2-4] This report presents observations on 11 patients with hyperactivity of the cardioinhibitory carotid sinus reflex. The recent comprehensive review of the pertinent literature by Draper[2] in his report of 11 cases renders further review repetitious.

It has been customary to evaluate the carotid sinus reflex with the patient in an upright position,[5,6] since it is largely in this position that syncope is produced by the cerebral effects of carotid sinus pressure. It occurred to us that performance of the test with the patient supine would eliminate cerebral effects, making it more strictly a test of cardiac inhibition. This was the procedure used by Purks[7] in his report of the electro-

The opinions contained in this article are the private ones of the authors and are not to be construed as official or reflecting the views of the Navy Department or Naval Service at large.

cardiographic findings in 67 cases. Although most observers[5,7] agree that the supine position may produce a smaller percentage of positive reactors, we believe that the specific implications in the reacting group are more significant.

At the beginning of this study it was intended that production of asystole for a period of two seconds or more would constitute a positive response. This would correspond with a 4 plus response, as classified by Sigler.[3] As the study progressed, it was observed that some patients who demonstrated asystole of two or more seconds on auscultation showed a shorter period by electrocardiogram. Since these patients demonstrated electrocardiographic abnormalities as a result of carotid sinus pressure, it was thought that they should be included as positive reactors. All of those so classified fall into the group "marked," according to Sigler's classification. Those patients who showed milder degrees of slowing were not considered in this series.

It has been shown that carotid sinus pressure for a prolonged period is not without danger, as evidenced by the production of anginal pain in 2 patients by Friedman[8] and the reports by several observers[9-11] of cerebral accidents after stimulation. It was, therefore, considered wise not to prolong carotid sinus pressure in patients who had definite overactivity of the carotid sinus. On the other hand, milder degrees of cardiac slowing have seemed to us normal since they occur in such a high percentage of normal healthy young people, and it was considered of no value to include them.

Report of Cases

Case 1.—R. R. R., a 67 year old white man, presented himself on July 25, 1949, complaining of vertigo and ataxia of three days' duration. These symptoms were first noted when he tried to get out of bed in the morning and could not assume the upright position because of them. There was slight nausea. He gave a history of mild dyspnea for three years with pedal edema and orthopnea for the past several weeks.

The physical examination revealed a white man who was chronically ill with slight cyanosis. The blood pressure was 180 systolic and 100 diastolic, and the pulse rate was 72. Moderate evidence of peripheral arteriosclerosis was present. The lungs were clear. Auscultation of the heart revealed a grade II systolic aortic murmur without a thrill. Flueroscopic examination revealed left ventricular enlargement, and the electrocardiogram showed a horizontal heart without definite abnormality. Pressure on the right carotid sinus resulted in no change in the cardiac rate (fig. 1). Left carotid sinus pressure produced a sinus arrest for 4.0 seconds, and ventricular asystole for 7.4 seconds, followed by a gradual resumption of the previous rate. The patient was then digitalized, and on Sept. 19, 1950, a repeat evaluation of carotid sinus sensitivity was made. Right carotid sinus pressure produced decided slowing of the cardiac rate with a temporary first degree auriculoventricular block, (P-R interval 0.25 seconds). Left carotid sinus pressure produced a sinus arrest for 4.3 seconds, and ventricular asystole for 6.4 seconds. A ventricular escape with a temporary complete auriculoventricular block was noted. On another occasion, left carotid sinus pressure produced a first degree auriculoventricular block (P-R interval 0.32 seconds) on the first escaping beat. It was further noted that the left carotid sinus pressure both before and after digitalization reproduced the complaints of faintness. Atropine to tolerance was without benefit as therapy.

This case of advanced heart disease demonstrates pronounced cardiac effects from stimulation of the carotid sinus prior to digitalization. After digitalization, right carotid sinus pressure produced decided slowing with a temporary first degree block, which effect was not noted initially.

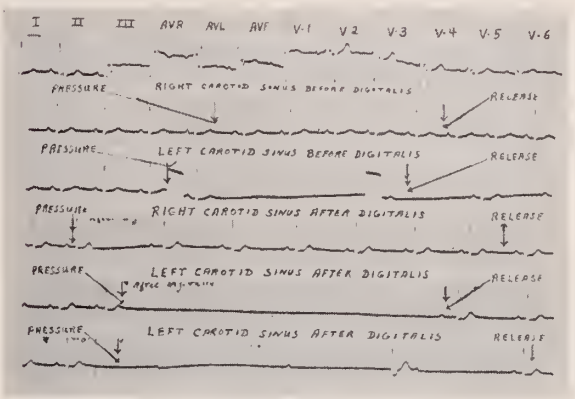


Figure 1

Case 2.—S. H. S., a 57 year old white man, suffered an acute anterior myocardial infarction in September 1948. Approximately three months after the infarction, the patient noted dyspnea on exertion and showed greatly diminished vital capacity. Because of the symptoms of congestive heart failure, he was digitalized in June 1949. In October of that year he complained of dizziness and numbness all over, particularly on turning his head.

The physical examination was not remarkable. There was no evidence of peripheral arteriosclerosis. The electrocardiogram revealed relics of an old anterior myocardial infarction. Right carotid sinus pressure produced a sinus arrest of 5.0 seconds' duration, and the establishment of an idioventricular rhythm (fig. 2). The patient complained of faintness and dizziness during the application of pressure on the carotid sinus. Left carotid sinus pressure produced an asystole of 1.5 seconds. The pressure on the left side, however, produced no complaints on the part of the patient. A report from his physician in November 1951 revealed that he subsequently omitted digitalis and cardiac effects could not then be demonstrated with carotid sinus pressure.

A case of severe myocardial disease, with previous acute infarction and digitalization for recent congestive failure, demonstrated cardiac standstill for a short period and establishment of a new pacemaker following pressure on either carotid sinus. Electrocardiographic changes occurred with left carotid sinus pressure without the production of symptoms. The subsequent disappearance of cardiac inhibition could be postulated on the absence of the effect of digitalis.

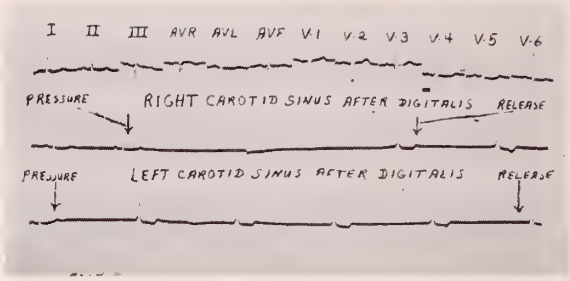


Figure 2

Case 3.—J. K., a 44 year old white man, had in 1949 an acute posterior myocardial infarction with typical electrocardiographic changes. Convalescence was satisfactory with disappearance of the typical electrocardiographic changes. In April 1950, he complained of periodic dizziness not definitely associated with turning the head.

The physical examination was not remarkable. The blood pressure was 150 systolic and 90 diastolic. Left carotid sinus pressure produced an asystole of 2.0 seconds with moderate slowing of the cardiac rate, and reproduction of the symptoms (fig. 3). Right carotid sinus pressure produced only slight slowing of the cardiac rate.

In this patient with definite heart disease, and a previous acute posterior myocardial infarction, there subsequently developed symptoms which could be reproduced by left carotid sinus pressure. He had not received digitalis.

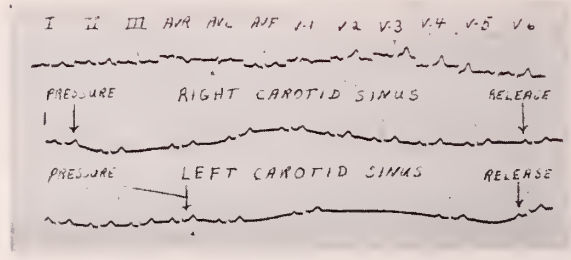


Figure 3

Case 4.—S. G. G., a 50 year old white man, was first seen on March 28, 1950, when he complained of momentary blackouts on leaning his head back. These blackouts had been noted over the course of the past two to three months.

The past history revealed that the patient had had chronic congestive heart failure for fifteen years. He had been tremendously obese, and had been successful in reducing his weight from over 400 pounds to 285. Much of this loss was attributed to the loss of fluid, subsequent to digitalization and diuretic therapy.

The physical examination revealed an obese white man with a blood pressure of 150 systolic and 100 diastolic, in the right arm, and 180 systolic and 110 diastolic in the left arm. Right carotid sinus pressure produced a slight slowing of the cardiac rate (fig. 4). Left carotid sinus pressure produced an asystole of 3.0 seconds, associated with a complete auriculoventricular block, and ventricular escape thereafter for the duration of the pressure. After release of the pressure, a first degree auriculoventricular block persisted for about 10 seconds.

The obese patient in this case with known chronic heart disease manifested effects and reproduction of his complaints by the application of left carotid sinus pressure. He was digitalized.

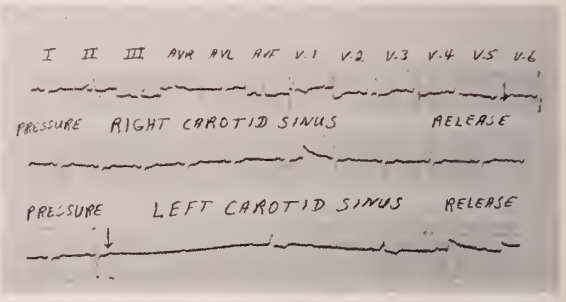


Figure 4

Case 5.—A. W. J., a 45 year old white man, was examined in September 1948. Six months previously, while extremely hot, he had suffered a brief attack of faintness and slight tightness substernally. He had no further complaints until about three weeks prior to examination, when he had another attack of faintness and tightness in the head while driving his car. This lasted from ten to fifteen minutes. There had been shortness of breath for the past three or four weeks, and a tight feeling in the chest on exertion. He had imbibed heavily of alcohol, and there had been dietary insufficiency.

The physical examination revealed a well developed and nourished man of 45 years who had a healthy appearance, but was nervous. The blood pressure was 150 systolic and 100 diastolic in both arms. The ocular fundi showed slight diminution in the caliber of the arterioles. The liver was hard, enlarged and nontender, and the edge was palpated 6 cm. below the right costal margin. Mild palmar erythema was noted. Fluoroscopic examination revealed great widening and tortuosity of the aortic arch with increased density of the aorta and mild rounding and elongation of the left ventricular border. The electrocardiogram was interpreted as being within normal limits. There was laboratory evidence of hepatic disease. Right carotid sinus pressure produced an asystole of 3 to 4 seconds' duration with reproduction of the subjective complaints. Left carotid sinus pressure produced a slowing of the cardiac rate.

In this mildly hypertensive patient with other minimal evidence of heart disease there developed symptoms which could be reproduced by the application of right carotid sinus pressure. He had cirrhosis and had not received digitalis.

Case 6.—E. S. M., a 59 year old white man, was examined in December 1948, five days subsequent to having suffered an attack of severe faintness and loss of equilibrium which could be reproduced by turning his head to the left. The family history revealed that the patient's father had suffered from diabetes at the age of 60.

The physical examination revealed a blood pressure of 130 systolic and 80 diastolic. There were moderate arteriosclerotic changes in the optic fundi, and arcus senilis was present. No evidence of heart disease was noted. The fasting blood sugar was 300 mg. per hundred cubic centimeters. The electrocardiogram was suspicious of an old posterior infarction. Right carotid sinus pressure produced no apparent change in the cardiac rhythm (fig. 5).

Left carotid sinus pressure produced a ventricular asystole of 5.5 seconds with reproduction of the subjective symptoms. During the ventricular asystole, two P waves were noted in the electrocardiographic pattern. After release of pressure, the rhythm returned to a normal rate in approximately 5 seconds. This patient had received no digitalis, but was receiving insulin daily at the time the electrocardiogram was taken.

In this case of diabetes mellitus, without manifest cardiac disease but with questionable electrocardiographic evidence of a posterior infarction, there developed an asystole lasting 5.5 seconds after left carotid sinus pressure.

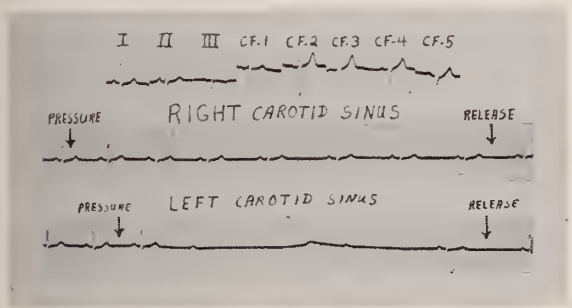


Figure 5

Case 7.—W. H. P., a 57 year old white man, when first examined in August 1949, complained of increasing dyspnea on exertion, orthopnea and pedal edema over the preceding eighteen months. There had been occasional paroxysms of violent coughing, productive of a foamy red sputum. He had been known to be hypertensive for seven years.

The physical examination revealed a rather obese acutely ill man. The blood pressure was 190 systolic and 110 diastolic in the right arm, and 220 systolic and 130 diastolic in the left arm. The optic fundi showed moderate generalized arteriolar narrowing with definite auriculoventricular compression. There was evidence of congestive heart failure with a loud blowing systolic apical murmur. Fluoroscopic examination revealed great elongation of the cardiac silhouette, rounding of the left ventricular contour, and widening of the aortic arch. An electrocardiogram showed a P-R interval of 1.8 to 2.0 seconds, and a typical complete left bundle branch block. All signs of cardiac decompensation cleared completely with digitalization and other routine therapy. Evaluation of carotid sinus sensitivity was done in November 1949, when pressure on the right produced a decided slowing of the cardiac rate, a variation in subsequent ventricular complexes, but no subjective response (fig. 6). Left carotid sinus pressure also produced a decided slowing of the rate, the longest period of asystole being 1.6 seconds. No P waves could be identified, and the rhythm appeared to be nodal in origin.

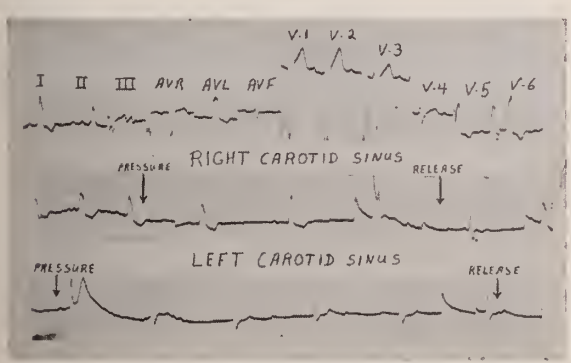


Figure 6

This case demonstrates increased auriculoventricular block and possible sinus arrest, as well as the establishment of a new pacemaker as a result of carotid sinus stimulation. The relative role of digitalis in this case cannot be evaluated. There were subjective symptoms from the carotid sinus hyperactivity.

Case 8.—H. M. R., a 73 year old white man, was first seen in November 1949, when he complained of pain in the anterior portion of the left side of the chest and subscapular pain, not related to exertion but related to motion of the thorax and left upper extremity. The past history revealed that he had been hypertensive for approximately three years. Four months prior to the present illness he had had an attack of severe epistaxis requiring blood transfusion.

The physical examination revealed a blood pressure of 180 systolic and 80 diastolic, arcus senilis, and moderate fundal arteriosclerosis. On fluoroscopy, left ventricular enlargement was present, and the electrocardiogram demonstrated a left axis deviation of plus 30 degrees. Right carotid sinus pressure produced slight slowing of the cardiac rate, and left carotid sinus pressure produced an asystole of 1.5 seconds, followed by a nodal rhythm (fig. 7).

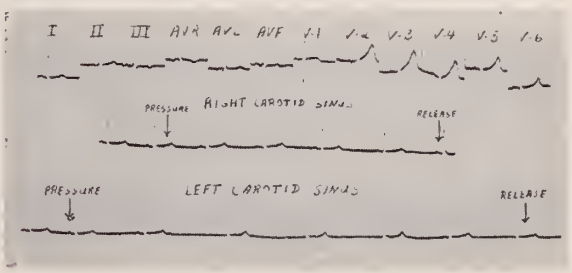


Figure 7

In this case an elderly white man with evidence of moderate generalized arteriosclerosis and fluoroscopic and electrocardiographic evidence of heart disease, presented definite cardiac changes after left carotid sinus pressure without subjective complaints.

Case 9.—J. H. C., a 50 year old white man, when first examined in June 1948, related that he had had frequent attacks of precordial distress precipitated by exercise since early in 1947. During this period, there had been no syncopal attacks. The history prior to that time, however, revealed an attack of severe constricting precordial pain lasting two to three hours in 1945. He then had no trouble until early 1947, when there were three syncopal attacks in one afternoon. These were accompanied by severe precordial pain with radiation to the arms. Serial electrocardiograms at this time showed a first degree auriculoventricular block (P-R interval 0.22 seconds) with prolonged intraventricular conduction (QRS interval 0.12 seconds). It was further shown in the serial tracings that these changes gradually returned toward normal over a period of 12 hours. The cardiologist at this time was of the opinion that the syncopal attacks may have resulted from a temporary complete heart block with Stokes-Adams syndrome. A duodenal ulcer had recently been demonstrated by roentgenogram.

Cardiovascular examination in June 1948 revealed mild arteriosclerotic changes in the optic fundi, slight left ven-

tricular enlargement by fluoroscopy and moderate obesity. The electrocardiogram revealed a QRS interval in lead 2 of 0.11 seconds with no significant ST or T wave abnormalities. An exercise test for electrocardiographic evidence

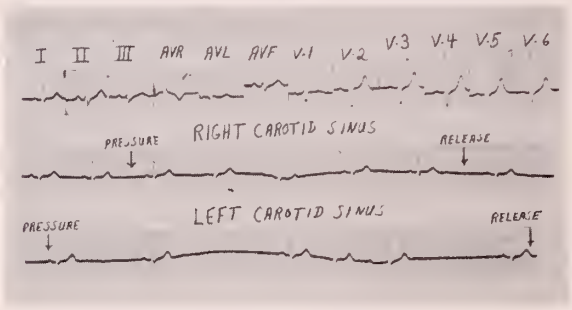


Figure 8

of coronary insufficiency gave negative results. As was noted previously, no further syncopal attacks occurred after early in 1947. Subsequently, however, right carotid sinus pressure produced a slight slowing of the cardiac rate, and left carotid sinus pressure produced asystole for 2.5 seconds followed by auricular ectopic beats and subjective faintness (fig. 8).

It would appear plausible in this case that the previous syncopal attacks may have resulted from carotid sinus effects. There is insufficient evidence to establish with certainty that complete heart block occurred in 1947, as a carotid sinus effect.

Case 10.—W. E. F., a 57 year old white man, presented himself with rather typical symptoms of a chronic recurrent duodenal ulcer, which had been present over a period of some twenty years. There were no symptoms referable to the cardiovascular system.

The physical examination revealed an asthenic healthy-appearing man with a normal blood pressure (120/78), arcus senilis and grade II arteriosclerotic changes in the optic fundi, in whom a cardiac examination gave negative results except for an occasional ectopic beat. There were diminished dorsalis pedis pulsations bilaterally, with mild changes of diminished arterial circulation in both feet. The heart was normal in size by fluoroscopy. An electrocardiogram revealed a vertical heart without abnormalities except for the presence of left ventricular premature beats. A duodenal ulcer was demonstrated by roentgenogram. Right carotid sinus pressure produced slight slowing of the rate (fig. 9). Left pressure produced asystole for 2.2 seconds, followed by a regular sinus rhythm, even though carotid sinus pressure was maintained.

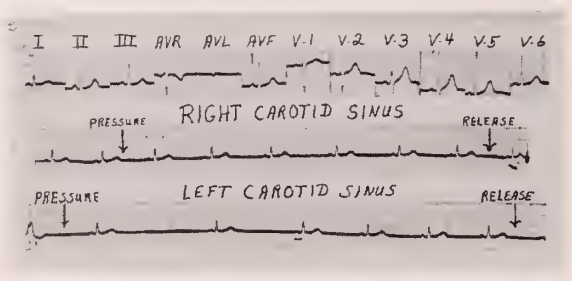


Figure 9

This patient, who had no manifest cardiac abnormalities except for ventricular premature contractions, showed moderate cardiac effects from carotid sinus stimulation without related symptoms.

Case 11.—W. H. B., a 60 year old retired Naval Chief Petty Officer, complained in November 1950 of "dizzy spells" of six months' duration, precipitated by assumption of a vertical position from a horizontal position. For a similar period he had had a precordial and substernal aching, radiating into the left shoulder on exertion. Occasionally, the dizziness and precordial pain had occurred concurrently. He knew his blood pressure had been about 150 systolic and 70 diastolic in the past.

The physical examination revealed a well developed and nourished healthy-appearing man in no apparent distress. The blood pressure was 94 systolic and 80 diastolic. The heart rate was grossly irregular, and the heart appeared enlarged from the physical findings. Roentgen examination disclosed left ventricular enlargement. The liver was palpable 2 cm. below the costal margin. Except for abdominal scars of cholecystectomy and appendectomy, the examination otherwise revealed no abnormalities. An electrocardiogram showed auricular fibrillation. After a few doses of quinidine, the rhythm became regular. It was then noted that the symptoms of dizziness and faintness were reproduced by right carotid sinus pressure. No electrocardiogram was taken with carotid sinus pressure.

The patient was readmitted to the hospital on May 6, 1951 and stated that he had experienced a prolonged attack of substernal pain two days previously, which had been

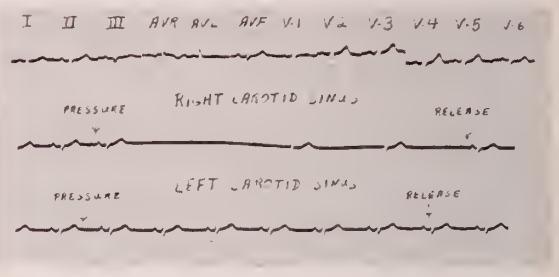


Figure 10

partially relieved by nitroglycerin. He had obtained relief from occasional episodes of angina with nitroglycerin. The dizziness on change of position was still present to a moderate degree. There had been no actual syncope. Serial electrocardiograms showed no significant change from the electrocardiogram taken prior to his discharge in December 1950. Right carotid sinus pressure reproduced the symptoms of faintness and weakness and produced asystole for 3.4 seconds followed by an auricular premature beat, then a nodal premature beat (fig. 10). Left carotid sinus pressure caused only a slight slowing of the rate. He was discharged and continued to take quinidine since he found that the auricular fibrillation recurred if he omitted it. Blood pressure changes from the supine to erect position were not remarkable. An exercise test produced no significant changes in the electrocardiogram.

This patient with rather typical angina, previous auricular fibrillation and left ventricular enlargement showed rather pronounced cardiac inhibition resulting from carotid sinus pressure. He was digitalized subsequent to the demonstration (on the electrocardiogram) of the carotid sinus effects, but had received no digitalis previously.

Table 1.—Analysis of Cases

Case	Asystole in Seconds	Subjective Symptoms	Heart Disease	Other Disease	Symptoms After Pressure
1	7.4	Yes	Yes	No	Yes
2	8.7	Yes	Yes	No	Yes
3	2.0	Yes	Yes	No	Yes
4	3.0	Yes	Yes	Obesity Hypertension Pyelonephritis	Yes
5	3.4	Yes	Yes	Cirrhosis Hypertension	Yes
6	5.5	Yes	Probable	Diabetes Duodenal ulcer Arteriosclerosis	Yes
7	1.6	No	Yes	Hypertension	No
8	1.5	No	Probable	Hypertension	No
9	2.5	No	Yes	Duodenal ulcer	Yes
10	2.2	No	Possible	Duodenal ulcer Arteriosclerosis	No
11	3.4	Yes	Yes	No	Yes

Discussion

Sigler[3] maintained that even mild degrees of cardiac slowing are suggestive evidence of heart disease. We believe that a mild degree is difficult to evaluate because of its presence in so many young, healthy persons and, therefore, not so valid a test as more pronounced cardiac inhibition. Nathanson[4] found that in the first 40 patients in whom he produced asystole by carotid sinus pressure, 34 had evidence of coronary disease of the anginal type. Our conclusions are more in accord with those of Nathanson,[4] who also found that only one third of his patients with definite coronary disease and angina showed a positive response to carotid sinus pressure. We have tested many patients with known heart disease, even those with recent and healing infarctions, and have found a positive response in relatively few. We believe, therefore, that a positive response as represented by asystole for two seconds or longer, or definite change in rhythm in the electrocardiogram, is, per se, strongly suggestive evidence that heart disease exists. Conversely, we believe a negative response has no inferential significance.

A review of the 11 cases of this series (table 1) reveals that in 8 the patient definitely had clinical heart disease. In the other 3, 1 patient (case 6) had diabetes, arteriosclerosis and duodenal ulcer; 1 (case 8) had hypertension; and 1 (case 10) had evidences of moderate arteriosclerosis. Three patients had duodenal ulcer, and 1 had cirrhosis. Case 1 demonstrates the well known effect of increased sensitization after digitalis. Case 2 illustrates a decided response while the patient was digitalized and no demonstrable response several months after digitalis was stopped. Four patients with a positive objective response had noted no subjective symptoms referable to the carotid sinus.

Summary

It is suggested that the carotid sinus be tested for cardiac response in the supine position to eliminate cerebral effects and, possibly, to diminish the cardiac response. Asystole for two seconds or electrocardiographically demonstrated changes in rhythm constituted a positive response in our series.

Eleven cases are presented with hyperactivity of the cardioinhibitory carotid sinus reflex. In 8 of these cases clinical heart disease was present and in the other 3 either hypertension or arteriosclerosis.

We conclude that a test giving positive results is strongly suggestive evidence of heart disease, but that a negative reaction has no definitive value, since many patients with known heart disease do not show a positive response.

Cardiac effects cannot be completely shown in many patients unless an electrocardiogram is taken during carotid sinus stimulation.

Subjective complaints are not necessarily present in patients with hyperactivity of the cardioinhibitory carotid sinus reflex.

References

1. Weiss, S., and Baker, J. P.: Carotid Sinus Reflex in Health and Disease; Its Role in Causation of Fainting and Convulsions, Medicine 12:297-354 (Sept.) 1933.
2. Draper, A. J.: Cardioinhibitory Carotid Sinus Syndrome, Ann. Int. Med. 32:700-716 (April) 1950.
3. Sigler, L. H.: Hyperactive Cardioinhibitory Carotid-Sinus Reflex as Aid in Diagnosis of Coronary Disease; Its Value Compared with That of Electrocardiogram, New England J. Med. 226:46-51 (Jan. 8) 1942.
4. Nathanson, M. H.: Rhythmic Property of Human Heart, Arch. Int. Med. 72:613-626 (Nov.) 1943.
5. Sigler, L. H.: Hyperactive Vasodepressor Carotid Sinus Reflex, Arch. Int. Med. 70:983-1001 (Dec.) 1942.
6. Askey, J. M.: Technique of Carotid Sinus Stimulation, California & West. Med. 63:266-267 (Dec.) 1945.
7. Purks, W. K.: Electrocardiographic Findings Following Carotid Sinus Stimulation, Ann. Int. Med. 13:270-279 (Aug.) 1939.
8. Friedman, M.: Anginal Syndrome as Manifestation of Hyperactivity of Carotid Sinus, Am. Heart J. 29:37-43 (Jan.) 1945.
9. Marmor, J., and Sapirstein, M. R.: Bilateral Thrombosis of Anterior Cerebral Artery Following Stimulation of Hyperactive Carotid Sinus, J. A. M. A. 117:1089-1090 (Sept. 27) 1941.
10. Askey, J. M.: Hemiplegia Following Carotid Sinus Stimulation, Am. Heart J. 31:131-137 (Feb.) 1946.
11. Zeman, F. D., and Siegal, S.: Monoplegia Following Carotid Sinus Pressure in Aged, Am. J. M. Sc. 213:603-607 (May) 1947.

U. S. Naval Hospital.

Treatment of Ventricular Tachycardia Report of a Resistant Case

WILLIAM P. LOGAN, M.D.
LAKELAND

In many cases of ventricular tachycardia quinidine has been used successfully in treatment although it is a potentially dangerous drug, particularly if administered intravenously. Recently, procaine amide ("pronestyl") also has proved effective in the treatment of this arrhythmia.

Even with these two drugs now available, however, ventricular tachycardia may present a difficult problem, as the case here presented illustrates. Although quinidine has a long history of use, there is still no well established therapeutic regimen. The following discussion, therefore, is centered around the successful use of quinidine after "pronestyl" failed to convert the arrhythmia to normal.

Report of Case

Mr. G. Y., a white man aged 59, had a myocardial infarction in 1946 and was re-examined in 1950, at which time he was asymptomatic with the electrocardiogram showing evidence of a previous infarction (fig. 1A). He became acutely ill on Jan. 23, 1951. The illness started during the evening meal with an acute pain in the left arm, which persisted for about an hour. The next morning, he was awakened at 4 a.m. with pain and air hunger of short duration. At breakfast, he became nauseated and vomited. His physician was summoned, and found the patient with a rapid heart rate and an enlarged liver. He was given 1.5 mg. of digoxin orally. An electrocardiogram (fig. 1B) taken at his home showed ventricular tachycardia with a rate of 196 per minute.

The patient was seen again on the following two mornings. Both times, he was given 0.5 mg. of digoxin. When the arryhthmia did not respond, he was sent to the hospital.

Upon admission, he was given quinidine, 0.2 Gm. every four hours. Oxygen was administered, and he was given a maintenance dose of digitalis. After 24 hours, the electrocardiogram still showed the presence of ventricular tachycardia at a rate of about 184 per minute.

Upon consultation, the patient was found to be moderately dyspneic though his lungs were clear to auscultation. The heart was enlarged with the left cardiac border just within the anterior axillary line. The blood pressure was 140 systolic and 80 diastolic. The edge of the liver was palpable 6 cm. below the costal margin and was tender. The dose of quinidine was then increased to 0.6 Gm. every four hours. The digitalis was stopped, and the congestive failure was treated with mercurial diuretics and ammonium chloride. With this dose of quinidine, the heart rate dropped to 114 per minute by the fifth dose. As it was not possible to secure an electrocardiogram at that time and since the patient was experiencing some gastrointestinal distress, the quinidine was stopped. By the next morning, however, the pulse rate was again up to 150 per minute.

At this time, eight days after the onset, it was decided to try procaine amide ("pronestyl"). The electrocardiogram showed a rate of 168 per minute (fig. 1C). The procaine amide was administered orally, 1.0 Gm. in the first two doses and 0.5 Gm. every four hours for 48 hours. With failure to convert to normal rhythm, the oral medication was discontinued, and "pronestyl" was given intravenously. According to the recommended dose, 1,000 mg. was given slowly with constant electrocardiographic recordings. This method also failed to produce slowing of the heart rate. No toxic effects were noted. Because of the newness of the drug and the inexperience in its use, it was decided to return to the use of quinidine, especially since it was thought that it had not been given an entirely fair trial.

By this time, the congestive failure had been well controlled. The liver had decreased in size considerably, and the patient felt well. Since there was no urgency, quinidine was started with an oral dose of 0.6 Gm. every three hours and continued for six days with the pulse rate varying between 152 and 122 per minute (fig. 2A). Only on rare occasions was it necessary to omit a dose because of gastrointestinal distress. As a result of failure to revert to normal rhythm at this dose level and because of good tolerance to oral medication, the quinidine was increased to 0.6 Gm. every two hours. The heart rate immediately began to fall, reaching 84 at one time, but the mechanism remained the same. At this high dosage, there were relatively few signs of toxicity though there were some gastrointestinal complaints of gas and bloating. Also, the patient became somewhat delirious, but the mental disturbance was found to be the result of uremia as shown by a high blood urea nitrogen. This was corrected promptly after the insertion of a retention catheter.

Ventricular tachycardia continued at about the rate of 100 per minute until the thirty-sixth dose or a total of 21.6 Gm. (360 grains) of quinidine had been administered. At this point, the nurse noted that the patient had become extremely cyanotic. Respirations were labored, and for a few moments she was unable to secure a pulse; however, it was soon palpable at a rate of 52 per minute, and the condition thereafter rapidly improved. An electrocardiogram taken shortly after this episode (fig. 2B) showed a normal rhythm at a rate of 51 per minute.

The oral dose of quinidine was immediately reduced to 0.6 Gm. three times a day and gradually reduced to a final dose of 0.2 Gm. three times a day, during which therapy, the normal rhythm remained.

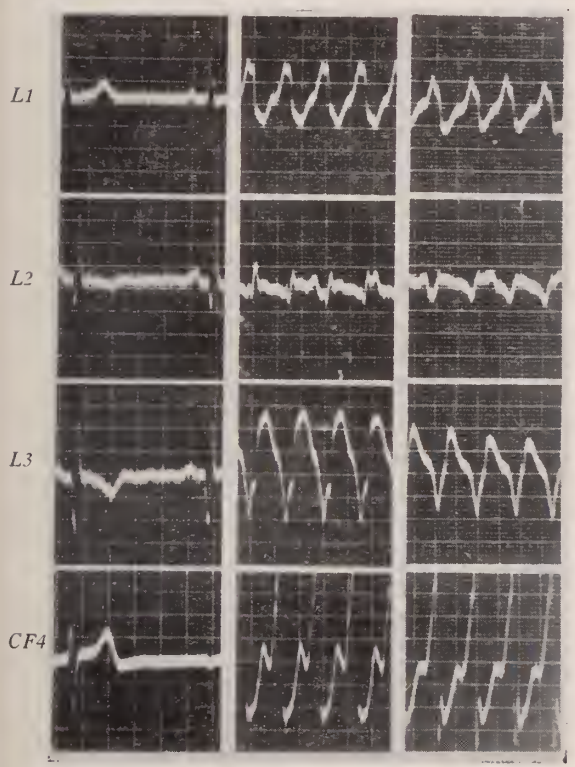
Subsequent examinations have shown the patient to be in good health (fig. 2C). The pulse rate rapidly returned to normal levels, and at the last examination, three months after the onset of the ventricular tachycardia, there remained a sinus rhythm (fig. 2D).

Discussion

While ventricular tachycardia is one of the less common types of cardiac arrhythmias, it is of frequent enough occurrence that every physician may be faced with its management, involving drugs in-

frequently used which require skill in their administration. Although the ultimate prognosis in cases of this type is usually poor because of underlying coronary or valvular cardiac conditions, the immediate prognosis is good, and the result of treatment may be dramatic and life-saving.

Figure 1



1A *Feb. 14, 1950* *1B* *Jan. 24, 1951* *1C* *Jan. 29, 1951*

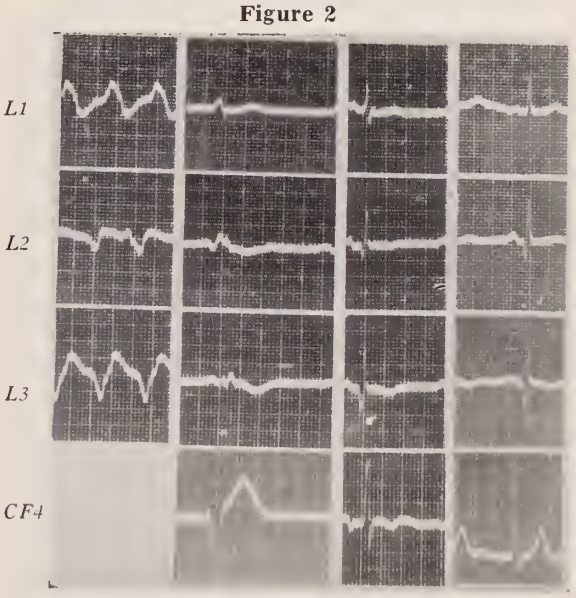
In the past, quinidine has been recognized as the drug of choice and the only drug of significant value in the treatment of ventricular tachycardia. In spite of this recognition, there has never been an agreement regarding the treatment regimen which would constitute a proper therapeutic trial. This lack is, perhaps, due to its infrequent use. The successful administration of this drug in conditions such as ventricular tachycardia requires skillful and intelligent management based on its pharmacologic properties and the physiologic reactions.

Quinidine is not an entirely safe drug. Serious complications have been reported, and objections to its use have been raised; however, the seriousness of ventricular tachycardia so overshadows the dangers of the drug itself that contraindications to its use are not to be considered. Toxic reactions, however, may definitely interfere with and complicate the use of the drug. The well known syndrome of cinchonism can occur with quinidine as with other quinine alkaloids. These symptoms may vary from mild ringing in the ears, headache, nausea and slight blurring of vision to more severe symptoms involving the gastrointestinal tract with vomiting, diarrhea and abdominal cramps, and the more serious toxic reactions of the nervous system which produce depression of respiration, excitement, confusion and stupor.[1]

While quinidine has many varied reactions on the heart, there is only one basic reaction which accounts for its success in the treatment of cardiac arrhythmias. This effect is an increase in the refractoriness of the various cardiac structures which causes a depression of the rhythmic activity of the idioventricular pacemaker.[2] This leads to one of the chief aims of treatment, which is to reduce the cardiac rate to between 110 and 120 per minute. The ultimate aim, that of conversion to a normal rhythm, may or may not have been reached by this point in the course of treatment. In any event, at this stage, the circulatory efficiency of the heart will have been returned toward normal.

Actually, it is not desirable to abolish the abnormal rhythm at once because there may not be another pacemaker ready to take over.[2] Such a condition will lead to a cardiac standstill. While not necessarily fatal, it will present an unpleasant time for all, with cyanosis, pallor, labored respiration, coma, or convulsions. This, no doubt, occurred at the time of conversion in this case. Fortunately, it was of no serious consequence and of short duration.

Figure 2



2A *Feb. 2, 1951* *2B* *Feb. 10, 1951* *2C* *Feb. 14, 1951* *2D* *June 17, 1951*

Quinidine is best given orally. It is usually recommended that a small test dose be given to detect any idiosyncrasy to the drug such as is manifested by dizziness, noise, shock, cyanosis, cold sweats, respiratory distress, and possibly urticaria. Fortunately, idiosyncrasy is rare, and it is possible that the necessity for such testing is greatly overemphasized and the need for such a test is in question.[2]

The size of the individual dose will vary with each patient and must be regulated according to clinical response and desired effect. It will usually vary from 0.2 Gm. to 0.6 Gm. More important than the size of the individual dose is the interval between doses. Quinidine is absorbed quickly and excreted rapidly so that the maximum blood concentration is reached in two to three hours.[3] By spacing the individual dose at less than four hour intervals, preferably three or even two hours, there is a pyramiding effect which will gradually raise the blood level. At a constant dose, taking advantage of the pyramiding effect, a plateau is reached in three to five days, at which time the full effect is reached and further dosage at that level will be of no further effect.[4]

Close clinical observation is necessary during the dosage manipulation. The heart rate should be checked before each individual dose, a decreasing rate being indicative of increasing quinidine effect. An electrocardiogram should be recorded when the rate is down to about 140 per minute. After this point, an electrocardiogram would be advisable after each third dose. Changes to be watched for are an increased QRS interval and an increased QT interval. Gold[2] emphasized the former, advising against continuation of the drug if the QRS interval is increased more than 50 per cent above that at the start of the treatment. As long as the QRS interval is satisfactory and if there is no conversion of the rhythm, quinidine should be continued until the heart rate reaches 120 to 110 per minute; then quinidine should be stopped and withheld until the heart rate again increases, thereby holding the heart rate at a level where the mechanical factors of heart efficiency are active, waiting while the physiologic readjustment of the heart restores the normal rhythm.[2]

Of course, it may not be possible to follow a case with as frequent electrocardiograms as suggested. When such is the case, the general principles must be kept in mind, and the best of clinical judgment must be used. The method of administering quinidine just described would seem to be best correlated with the drug's action and physiologic response of the heart.

The management of the case presented was based on this plan. Because of the rather remarkable tolerance to quinidine administered orally, it was all given by mouth. The original dosage before procaine amide was tried was definitely inadequate. Following the failure of procaine amide to convert the rhythm to normal, quinidine was started again, 0.6 Gm. every three hours. No doubt, a plateau of effectiveness was reached on this dose schedule so that it was then increased to 0.6 Gm. every two hours. On this dose, the heart rate dropped to within range of circulatory efficiency, but the arrhythmia continued. Perhaps, if the quinidine had then been stopped and the rate maintained at this level by whatever subsequent doses were necessary, the period of cardiac standstill would have been avoided. But would the conversion have occurred?

Other methods of administration have been suggested and may be just as effective. Certain authors[5] believed that the most significant factor is the largest single dose that is required to produce conversion and that the actual blood level is not as significant. In such a regimen, the patient is given 0.2 Gm. initially, and the dosage is then increased by 0.2 Gm. every four hours until conversion takes place. Another method[3] is that of increasing the dose in a series of courses. In such a method, the patient would be given 0.4 Gm. every two hours until the arrhythmia is broken or until five doses have been given. This therapy is repeated for two to three days, increasing the dose by 0.2 Gm. on each day.

After conversion of the abnormal rhythm, there will be needed a maintenance dose. This will have to be regulated to each individual case, with employment of the smallest dose to control the rhythm. It should be continued for as long as necessary. The appearance of premature ventricular extrasystoles is indicative of possible return of the ventricular tachycardia, and, therefore, the need to increase the dose. In this case, the dose was rapidly decreased, reaching the level of 0.2 Gm. three times a day. This maintenance dose has successfully prevented the return of the tachycardia.

In the event that the oral route is not tolerated, an intramuscular form is now available. This is supplied in a 20 per cent solution in propylene glycol in an ampule containing 0.2 Gm. (3 grains)

in one cubic centimeter. This preparation, it is claimed, produces negligible local reaction at the site of injection. The curve of action is much the same as for the oral medication. In one study of this method of dosage,[6] it was found that 0.4 Gm. every six hours produced a plateau effect after about four to six doses.

Quinidine lactate, 0.65 Gm., may also be given intramuscularly[7] with no more toxic effect than by oral administration. If rapid action is needed such as would be used with ventricular tachycardia, it is advisable to give the dose every hour. The maximum effect is reached in 30 minutes, and the effect persists three to four hours.

Intravenous use is dangerous, and should be resorted to only as a heroic measure when the patient's condition is considered critical.[3,8] A solution of quinidine for intravenous use can be prepared by dissolving 0.2 Gm. in 20 cc. of normal saline (a 1 per cent solution which must be freshly dissolved when used). A quinidine lactate solution is also used.[7,9,10] This is supplied in an ampule of 0.65 Gm. dissolved in sterile saline. Each ampule is diluted with 50 cc. of 5 per cent glucose and given slowly, 1 to 2 cc. per minute. This solution should be given slowly, the apical rate being carefully observed. As the injection proceeds, the blood pressure will tend to drop, the respirations will deepen and become labored, and the heart sounds will become distant and the rate slower.

Of course, injections should cease as soon as the ectopic rhythm is converted to normal. If conversion does not occur, the injection is continued until the pulse slows by 25 beats or more or the heart sounds become feeble or respirations poor, the interrupted injections being started again when these conditions improve. The injections are then continued until the heart slows to 120 beats per minute. Continuous electrocardiographic recordings are helpful if not essential.

Procaine amide has recently been introduced for the treatment of ventricular arrhythmias.[11-15] It has been shown to be effective and also to cause relatively few toxic reactions. As with quinidine, the oral route of administration is considered the method of choice. It is usually administered in a dose of 0.5 to 1.0 Gm. every four hours. The effective oral dose, however, varies widely. Intravenous medication may be more effective than the oral, and toxic reactions are much less severe or frequent than with the use of quinidine. But again, the toxic manifestations following intravenous administration are more alarming when they occur in patients given the oral preparation. The drug is administered intravenously at a rate not to excced 100 mg. per minute under constant electrocardiographic control, until there is a return to a normal sinus rhythm, or until toxic reactions are observed or a total of 1 Gm. has been given.

Of the toxic reactions, hypotension is the most serious manifestation and practically all patients manifest some degree of hypotension with intravenous administrations while it is rarely observed when the oral route is employed. The hypotension may produce severe secondary reactions such as cardiac angina or convulsions. Nausea and vomiting may occur with the oral preparation. The electrocardiographic effects consist of slowing of the ventricular rate, P-R and QT prolongations, T wave flattening and QRS widening. Such changes usually occur with intravenous administration, but they occur often enough with the oral route to warrant electrocardiographic control. In general, the toxic effects are similar to those occurring with quinidine, though they are much less pronounced.

Nausea and vomiting are usually not considered indications for stopping the therapy. Severe hypotension or associated reactions, however, and a considerable degree of widening of the QRS are indications for stopping the drug.

Because of the advantages offered by this drug, quinidine was stopped after conversion failed to occur during the early part of the treatment in the case reported. Procaine amide was then given in the dosages mentioned without results. Because of the newness of the drug and inexperience in its use, no further attempts were made, and quinidine was given again with eventual conversion to a normal rhythm. Certainly, in this case, at the dosage given, procaine amide therapy was entirely unsuccessful.

Other drugs[8] have been used in the treatment of ventricular tachycardia and their use reported as successful. Since, however, the prognosis is generally poor due to the usually underlying cardiac condition and the danger of congestive failure and ventricular fibrillation is ever present, one should promptly and exhaustively use quinidine and procaine amide; then if the rhythm has failed to convert, one can try these other methods. Such methods include the use of atabrine, potassium salts alone or in a combination with quinidine, magnesium salts, intravenous morphine, carbachol,

the vagolytic action of atropine in large doses after partial slowing of the heart by quinidine, papaverine, ergotamine and stellectomy.

The question of the use of digitalis[2,16] in such cases almost always arises. It has, in the past, been generally accepted that digitalis is contraindicated and because of this fact, it was stopped in this case. More recently, however, the opinion has been advanced that digitalis is not detrimental, and, in fact, its freer use in these cases when needed for congestive failure has been recommended.

Summary

A case of ventricular tachycardia is reported in which there was failure to respond to the use of procaine amide, with subsequent reversion to a normal rhythm after persistent use of quinidine in large doses. Included in the presentation is a review of the therapeutic regimen advised in the use of quinidine and procaine amide.

References

1. Goodman, L. S., and Gillman, A.: The Pharmacological Basis of Therapeutics, A Textbook of Pharmacology, Toxicology and Therapeutics for Physicians and Medical Students, New York, The Macmillan Company, 1944.
2. Gold, H.: Quinidine in Disorders of the Heart, New York, Paul B. Hoeber, Inc., 1950.
3. Katz, L. N.: Quinidine, J. A. M. A. 136:1028-1031 (April 17) 1948.
4. Yount, E. H., and Rosenblum, M.: Studies of Plasma Quinidine Levels in Relation to Therapeutic Effect and Toxic Manifestations, South. M. J. 43:324-329 (April) 1950.
5. Armbrust, C. A., Jr., and Levine, S. A.: Paroxysmal Ventricular Tachycardia: Study of One Hundred and Seven Cases, Circulation 1:28-40 (Jan.) 1950.
6. Gluck, J. L., and others: Quinidine Sulfate in Propylene Glycon by Intramuscular Injection in Man, J. A. M. A. 145:637-640 (March 3) 1951.
7. Blinder, H., and others: Studies on the Effects of Parenteral Quinidine Administration, A. M. A. Arch. Int. M. 86:917-933 (Dec.) 1950.
8. Pordy, L.; Kolker, L., and Levy, H.: Paroxysmal Ventricular Tachycardia of Prolonged Duration, Am. J. Med. 10:254-268 (Feb.) 1951.
9. Herrmann, G. R., and Hejtmancik, M. R.: Clinical and Electrocardiographic Study of Paroxysmal Ventricular Tachycardia and Its Management, Ann. Int. Med. 28:989-997 (May) 1948.
10. Clagett, A. H., Jr.: Intravenous Use of Quinidine, with Particular Reference to Ventricular Tachycardia, Am. J. M. Sc. 220:381-388 (Oct.) 1950.
11. Miller, H.; Nathanson, M. H., and Griffith, G. C.: The Action of Procaine Amide in Cardiac Arrhythmias, J. A. M. A. 146:1004-1007 (July 14) 1951.
12. Mark, L. C., and others: The Action of Procaine Amide on Ventricular Arrythmias, J. Pharmacol. & Exper. Therap. 98:21 (Jan.) 1950.
13. Kayden, H. J.; Steele, J. M.; Mark, L. C., and Brodie, B. B.: The Use of Procaine Amide in Cardiac Arrythmias, Circulation 4:13-22 (July) 1951.
14. Irvin, C. W., Jr., and Cutts, F. B.: Ventricular Tachycardia; Report of a Case in Which "Pronestyl" Was Effectively Used After Failure with Quinidine, J. A. M. A. 146:1282-1283 (Aug. 4) 1951.
15. Berry, K.; Garlett, E. L.; Bellet, S., and Gefter, W. I.: Use of Pronestyl in the Treatment of Ectopic Rhythms, Treatment of Ninety-Eight Episodes in Seventy-Eight Patients, Am. J. Med. 11:431-441 (Oct.) 1951.
16. Gilson, J. S., and Schemm, F. R.: The Use of Digitalis in Spite of the Presence of Ventricular Tachycardia, Circulation 2:278-285 (Aug.) 1950.

Box 1021.

ABSTRACTS OF MEDICAL ARTICLES

Tumors of the Spermatic Cord, Review of Literature and Report of Two Cases. By Raymond J. Fitzpatrick, M.D., Louis M. Orr, M.D., James B. Glanton, M.D., and Joseph C. Hayward, M.D. J. A. M. A. 148:259-261 (Jan. 26) 1952.

This paper has a twofold objective. The first is to report 2 cases of tumor of the spermatic cord, a spindle cell sarcoma and a lipoma. The case of spindle cell sarcoma is of particular interest because of the unusually long time of survival, almost fourteen years after surgery, with ultimate death from long-delayed metastases.

Secondly, an attempt is made to arrive at an accurate count of the cases reported to the present time. The 2 cases presented in this paper bring the total number to 286. The authors observe that the difficulties encountered in compiling accurate statistical data stress the need for investigators to analyze critically previous reports and additions to the literature.

Evaluation of Liver Biopsy as a Diagnostic Procedure. By Chester Cassel, M.D., Frank C. Bone, M.D., Julian M. Ruffin, M.D., Leland D. Stoddard, M.D. Am. Pract. 2:745-754 (Sept.) 1951.

In a study of the usefulness and the limitations of needle biopsy in the diagnosis of hepatic disease, a series of cases is analyzed in which 174 biospies were made on 162 patients. Seven cases exemplifying the usefulness of liver biopsy as a diagnostic procedure are described.

The authors' conclusions follow: In diffuse hepatic involvement, a definite pathologic diagnosis is usually possible. Focal lesions, however, may be missed completely; a biopsy giving negative results, therefore, does not exclude such lesions as neoplasm or disseminated tuberculosis. In difficult cases in which clinical and laboratory data are inconclusive, correct differentiation between parenchymatous and obstructive jaundice is frequently possible.

In addition to establishing the diagnosis of hepatitis and cirrhosis, needle biopsy gives information of value in prognosis. Serial biopsies may demonstrate the progress of disease or the results of therapy. This procedure sometimes discloses conditions unsuspected clinically or systemic diseases incidental in the liver. Too, by revealing the cause of hepatomegaly or jaundice it may obviate laparotomy.

In experienced hands, biopsy of the liver has proved a relatively safe and useful, though not infallible, diagnostic procedure on carefully selected patients, but the inherent dangers demand utmost caution, both in the choice of patients and in the performance of the procedure.

The Effect of Intravenous Papaverine Hydrochloride on the Cerebral Circulation. By H. W. Jayne, P. Scheinberg, M. Rich, and M. S. Belle with the technical assistance of Ione Blackburn. J. Clin. Investigation 31:111-114 (Jan.) 1952.

The purpose of this paper is to report the findings on the effects of intravenous papaverine on cerebral blood flow and metabolism in 18 subjects, as measured by the nitrous oxide technic.

It was found that intravenous papaverine hydrochloride, in doses of 0.2 Gm. administered in 20 minutes, results in a 13 per cent increase in cerebral blood flow, a commensurate decrease in arterial-cerebral venous oxygen difference, with no change in cerebral oxygen consumption, and a decrease in cerebral vascular resistance and cerebral venous oxygen tension. It is concluded that the mechanism whereby papaverine increases cerebral blood flow and decreases vascular resistance is its direct vasodilating effect on cerebral vessels.

The Neurosurgical Aspects of Spontaneous Subarachnoid Hemorrhage. By J. G. Lyerly, M.D. South. M. J. 44:936-942 (Oct.) 1951.

The clinical findings associated with spontaneous subarachnoid hemorrhage may simulate those of such intracranial lesions as meningitis, abscess, tumor and various toxic conditions with meningeal irritation. The diagnosis of this condition is established by means of a careful neurologic examination with spinal fluid studies. The cause may be a ruptured aneurysm, leakage into the spinal fluid spaces from an intracerebral hemorrhage with arteriosclerosis, hemorrhage from a brain tumor or a vascular anomaly, or bleeding associated with meningitis or encephalitis.

Dr. Lyerly notes that the patient may survive the first rupture of an intracranial aneurysm, but that a second rupture, frequently fatal, may be expected two or three weeks later. A third one is more often fatal. He advocates search for the intracranial aneurysm in each case by means of an arteriogram with 35 per cent iodopyracet.

He observes that the treatment of an intracranial aneurysm may require a fractional ligation of the internal carotid or common carotid artery in the neck, with an intracranial exposure in suitable cases to trap off the vessels about the aneurysm. The 7 cases presented illustrate his technic of preliminary carotid ligation followed by intracranial attack on the lesion and demonstrate the effectiveness of surgical intervention in the handling of a condition which could carry a particularly high mortality under conservative management.

Nonspecific Granuloma of Rectum and Sigmoid Colon, Lesions of Rectum and Sigmoid Colon Which Clinically Simulated Cancer but Which Responded to Aureomycin Therapy. By Martin S. Belle, M.D., Sidney Fox, M.D., and Ralph Allen, M.D. A. M. A. Arch. Int. Med. 88:685-691 (Nov.) 1951.

Two cases of granulomatous lesion of the rectum and sigmoid are reported in which the lesions were thought to be malignant, but after thorough study, including biopsy, were proved to be nonspecific granulomas. A review of the literature of the last fifteen years revealed only one similar case reported.

Care was taken to rule out lymphogranuloma venereum, amebiasis, syphilis, tuberculosis, schistosomiasis, gonorrhea, and other diseases of bacterial origin. In view of the history of gradually increasing obstipation with blood in the stools, the gross appearance and feel of the tumors, and the presence of pronounced asthenia, loss of weight and fever, a diagnosis of carcinoma was the working hypothesis until repeated biopsy directed attention to other possibilities.

Cure of the lesions with aureomycin therapy is described. The authors emphasize the clinical similarity of these granulomas to carcinoma of the rectum and sigmoid colon and consider it important to try treatment with aureomycin in all cases of nonspecific granuloma of the rectum and sigmoid colon before resection is considered.

An Evaluation of the Treatment of Thyroiditis. By J. Harold St. John, M.D., and William M. Nicholson, M.D. South. M. J. 44:1059-1062 (Nov.) 1951.

During the decade from 1940 to 1950, 40 patients with acute recurring thyroiditis were treated at Duke Hospital. Of this number, 32 were females. The disease occurred more frequently in the age group of 41 to 50 years; the youngest patient was 3 years of age and the oldest 74. The 7 Negro patients represented a proportion roughly following the ratio of white to Negro patients observed in the clinic there.

A study of this series of cases convinced the authors that, despite the economic disadvantage, the therapy of choice is complete bed rest for an indefinite period of time, to be determined by the course of the patient's illness. They advised roentgen therapy also, since it appears to shorten the duration of the acute symptoms, and analgesics in the form of aspirin for the control of pain. It was their opinion that antibiotics and chemotherapy, the latter including thiourea and its derivatives and arsphenamine, have no value in changing the course of this illness.

Enterogastrone Parenterally in the Treatment of Peptic Ulcer: A Controlled Clinical Study. By Frank C. Bone, M.D., Chester Cassel, M.D., Julian M. Ruffin, M.D., and Robert J. Reeves, M.D. Gastroenterology 17:35-38 (Jan.) 1951.

In an attempt to determine the effectiveness of enterogastrone, an extract of hog intestine, in the treatment of peptic ulcer, the authors studied 36 patients with typical history and severe symptoms of peptic ulcer. Of this number, 20 received enterogastrone and 16 a placebo similar in appearance, without the investigators knowing which was enterogastrone and which the placebo until the final results had been evaluated.

In both groups, the results were similar. Slightly over half of each group improved during the treatment period, and the majority lapsed into the pretreatment state when the preparations were discontinued. No significant difference in roentgen findings, gastric acidity, or volume of secretion was noted between the group receiving enterogastrone and the control group. It was therefore concluded that the preparation of enterogastrone used in this study is ineffective in the treatment of patients with peptic ulcer.

Lymphocytoma of the Skin, Report of an Unusual Case (Lymphocytoma Tumidum.) By Morris Waisman, M.D., and Renzo G. Olivetti, M.D. A. M. A. Arch. Dermat. & Syph. 64:761-766 (Dec.) 1951.

Although the entity of lymphocytoma of the skin has only recently been discussed in American dermatologic literature, the disease has long been recognized, both as lymphocytoma and as Spiegler-Fendt sarcoid. The clinical picture is variable, with lesions usually on the face, characterized by small size, slow growth, absence or paucity of subjective symptoms, and no intrusion of cancerous change. Of highly differentiated lymphoid tissue, with or without germinal centers, the lesions pursue a benign course, persisting at times indefinitely or disappearing spontaneously. They are generally highly sensitive to roentgen irradiation.

A case is reported because it represents an unusual clinical form of the disease (lymphocytoma tumidum), because there was no response to filtered roentgen radiation, and because there was apparently favorable response to combined treatment with penicillin and aureomycin after these antibiotics had been administered separately without significant effect.

The great shrinkage of the tumor almost immediately after administration of penicillin and aureomycin concurrently suggests that this combination of antibiotics (synergism?) was responsible for the involution of the lesion, although the authors do not dismiss entirely the possibility of delayed roentgen effect or even spontaneous healing. They conclude that the therapeutic observations, together with the histopathologic characteristics, strongly suggest an infectious origin for lymphocytoma.

Medical Management of Renal Lithiasis. By Arthur J. Butt, M.D., Ernst A. Hauser, Ph.D., and Joseph Seifter, M.D. California Med. 76:123-129 (March) 1952.

Since urine is a highly saturated solution due to the presence of certain colloids, the authors observe that the protective action of urinary colloids is of major importance in preventing precipitation, agglomeration and conglomeration of crystalloids from a supersaturated solution. If the concentration of such protective colloids is insufficient, stone formation begins or is accelerated. Their study of 680 human subjects revealed that the incidence of

stone was almost inversely proportional to the degree of protective urinary colloids present. Urine specimens were subjected to ultramicroscopic examination, determination of electric charge carried by the colloidal particles, determination of the surface tension, and photoultramicrographic studies.

Subcutaneous injection of hyaluronidase mixed with physiologic saline solution greatly increases the content of protective colloids in the urine. The colloids are caused to set up to a gel, thereby preventing electrolytes present from crystallizing. They act as excellent dispersing agents and prevent the formation of stone.

Hyaluronidase therapy, using 150 turbidity reducing units every 24 to 72 hours, was effective in preventing calculous formation or reformation during a period of 11 to 14 months in 18 of 20 patients in whom, previously, stones formed rapidly. In a second series of ten patients in whom stones formed rapidly, larger doses of hyaluronidase, averaging 300 turbidity reducing units every 24 to 48 hours, were given. The period of observation at the time of report was from six to ten months. In this group, there was no new stone formation or enlargement of existing stones as evidenced by roentgen studies at intervals of 30 to 60 days.

Charcot Joints and Infectious-vascular Lesions of Bones in Diabetes Mellitus. By Barkley Beidleman, M.D., and Garfield G. Duncan, M.D. Am. J. Med. 12:43-52 (Jan.) 1952.

The authors point out that in patients with diabetes mellitus there may develop destructive lesions of the bones of the foot, demonstrable by roentgen ray examination. These lesions are of two types: gradual dissolution of the tarsal bones and their articulations (the Charcot joint), attributable to diabetic neuropathy; and rarefaction of the phalanges and metatarsals secondary to chronic infection in the adjacent soft tissues and arterial insufficiency.

Four illustrative cases of Charcot joint in diabetes mellitus are reported, in 2 of which, in addition, the second type of bony lesion was present. The differentiating characteristics of the two types of lesions are summarized in a table. In view of the usually excellent correlation in these 4 cases and in similar ones between the duration and severity of diabetic neuropathy and the development of changes in the bones of the ankle and their articulations similar to those described in Charcot joints due to other diseases, there would seem to be, in the opinion of the authors, little doubt as to the cause and effect relationship between the neuropathy and these particular bony changes. The nature of this relationship is, however, not clearly defined nor is the manner in which diabetes initiates the entire process. The pathogenesis of the second type of lesion may be more open to question, they conclude.

A Florida Pollen Study. By John M. McDonald, M.D. South. M. J. 45:616-618 (July) 1952.

This article reports a statewide pollen study begun in February 1950, in which special attention was given to ragweed pollen, but tree and grass pollen counts were also recorded. For the first year twenty-one pollen traps were in operation, about 100 miles apart and all but three in coastal areas. Most of the servicing was done by county health department personnel.

It is evident from the study that the air of the Florida beaches contains little ragweed pollen; the counts for Key West, Miami Beach and Fort Myers being exceedingly low. Clinical evidence indicates that residence in these areas provides great relief from symptoms in patients sensitive to ragweed pollen. In the other cities listed, Bradenton, Daytona Beach, Fort Myers, Jacksonville, Miami, Pensacola and St. Petersburg, hay fever sufferers may expect to be comfortable except for a few days each year, especially if living as near the beach as possible. While the season for ragweed pollen is prolonged in Florida in comparison with the season in Northern states, the counts are relatively low. Also, the peak date is widely variable in different localities.

Grass pollen is seen from March to December, the peak count usually coming in April or May. Florida has 28 varieties of oak trees, all apparently prolific producers of pollen. In the St. Petersburg area, oak pollination begins in January, reaches a peak about February 17 and disappears in March. The season is some three weeks later in Orlando and still two weeks later around Tallahassee and Jacksonville. Pecan pollen in small amounts has been observed on slides in North Florida. Pine pollen is produced in enormous quantities in January and February, but is not generally considered to be a factor in pollinosis.

FLORIDA MEDICAL ASSOCIATION

OFFICERS AND COMMITTEES

OFFICERS

ROBERT B. MCIVER, M.D., President.....*Jacksonville*
FREDERICK K. HERPEL, M.D., Pres.-elect..*West Palm Beach*
FRANCIS H. LANGLEY, M.D., 1st Vice Pres...*St. Petersburg*
ERASMUS B. HARDEE, M.D., 2nd Vice Pres.....*Vero Beach*
H. QUILLIAN JONES, M.D., 3rd Vice Pres.....*Fort Myers*
SAMUEL M. DAY, M.D., Sec'y-Treas.....*Jacksonville*
SHALER RICHARDSON, M.D., Editor.....*Jacksonville*

MANAGING DIRECTOR

STEWART G. THOMPSON, D.P.H.....*Jacksonville*
ERNEST R. GIBSON, Assistant.....*Jacksonville*

BOARD OF GOVERNORS*

ROBERT B. MCIVER, M.D., Chm...(Ex Officio).*Jacksonville*
JAMES L. BORLAND, M.D...AL-53.....*Jacksonville*
DUNCAN T. MCEWAN, M.D...B-53.....*Orlando*
JAMES H. POUND, M.D...A-54.....*Tallahassee*
NORVAL M. MARR, M.D...C-55.....*St. Petersburg*
JOHN D. MILTON, M.D...D-56.....*Miami*
HERBERT E. WHITE, M.D...PP-53.....*St. Augustine*
DAVID R. MURPHEY, JR., M.D...PP-54.....*Tampa*
FREDERICK K. HERPEL, M.D. (Ex Officio).*W. Palm Beach*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*
HERBERT L. BRYANS, M.D...S.B.H.-53.....*Pensacola*
STEWART G. THOMPSON, D.P.H. (Advisory)...*Jacksonville*

*SUB-COMMITTEES

1. Veterans Care
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
GEORGE M. STUBBS, M.D.....*Jacksonville*
DOUGLAS D. MARTIN, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

2. Advisory to National Foundation Infantile Paralysis
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
H. PHILLIP HAMPTON, M.D.....*Tampa*
ROBERT P. KEISER, M.D.....*Coral Gables*
RICHARD G. SKINNER, JR., M.D.....*Jacksonville*

3. Review of Fee Schedules
JOHN D. MILTON, M.D., Chm.....*Miami*
WOODROW B. ESTES, M.D.,.....*St. Petersburg*
FREDERICK H. BOWEN, M.D.....*Jacksonville*
ODIS G. KENDRICK, JR., M.D.....*Tallahassee*
JAMES B. GLANTON, M.D.....*Orlando*
FLOYD K. HURT, M.D.....*Jacksonville*
HERSCHEL G. COLE, M.D.....*Tampa*
A. FRANKLIN HARRISON, M.D.....*Madison*
JACK O. W. RASH, M.D.....*Miami*
KENNETH S. WHITMER, M.D.....*Miami*
ADELBERT F. SCHIRMER, M.D.....*Orlando*

4. Blue Shield
LEIGH F. ROBINSON, M.D., Chm.....*Fort Lauderdale*

SCIENTIFIC WORK

JAMES N. PATTERSON, M.D., Chm...AL-53.....*Tampa*
CAROL C. WEBB, M.D...A-53.....*Pensacola*
FREDERICK K. HERPEL, M.D...D-54.....*West Palm Beach*
JERE W. ANNIS, M.D...C-55.....*Lakeland*
RICHARD C. CUMMING, M.D...B-56.....*Ocala*

LEGISLATION AND PUBLIC POLICY

H. PHILLIP HAMPTON, M.D., Chm...B-53.....*Tampa*
WILLIAM M. ROWLETT, M.D...AL-53.....*Tampa*
DANIEL A. MCKINNON, M.D...A-53.....*Marianna*
ANGUS D. GRACE, M.D...C-55.....*Fort Myers*
DONALD W. SMITH, M.D...D-56.....*Miami*
ROBERT B. MCIVER, M.D. (Ex Officio).....*Jacksonville*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*

MEDICAL EDUCATION AND HOSPITALS*

JACK Q. CLEVELAND, M.D., Chm...AL-53.....*Coral Gables*
JULIUS C. DAVIS, M.D...A-53.....*Quincy*
ELBERT MCLAURY, M.D...D-54.....*Hollywood*
S. CARNES HARVARD, M.D...C-55.....*Brooksville*
BENJAMIN F. DICKENS, M.D...B-56.....*Fernandina*

*SPECIAL ASSIGNMENT

1. Urge Gifts to American Medical Education Foundation

PUBLIC RELATIONS*

EUGENE B. MAXWELL, M.D., Chm...AL-53.....*Tampa*
LEIGH F. ROBINSON, M.D...D-53.....*Fort Lauderdale*
HOWARD V. WEEMS, SR., M.D...C-54.....*Sebring*
EUGENE G. PEEK, JR., M.D...B-55.....*Ocala*
HENRY L. SMITH, JR., M.D...A-56.....*Tallahassee*

*SPECIAL ASSIGNMENTS

1. Rural Educational Program
2. State Education Campaign

NECROLOGY

ALVIN L. STEBBINS, M.D., Chm...A-56.....*Pensacola*
HUGH WEST, M.D...AL-53.....*DeLand*
JOSEPH HALTON, M.D...C-53.....*Sarasota*
WALLACE H. MITCHELL, M.D...D-54.....*Key West*
JOSEPH J. LOWENTHAL, M.D...B-55.....*Jacksonville*

MEDICAL POSTGRADUATE COURSE

TURNER Z. CASON, M.D., Chm...B-55.....*Jacksonville*
ARTHUR J. BUTT, M.D...AL-53.....*Pensacola*
FRANZ H. STEWART, M.D...D-53.....*Miami*
J. BROWN FARRIOR, M.D...C-54.....*Tampa*
FRANCIS T. HOLLAND, M.D...A-56.....*Tallahassee*

CANCER CONTROL

FRAZIER J. PAYTON, M.D., Chm...D-54.....*Miami*
MILTON C. MALONEY, M.D...AL-53.....*Jacksonville*
ROBERT L. TOLLE, M.D...B-53.....*Orlando*
GEORGE W. MORSE, M.D...A-55.....*Pensacola*
WESLEY W. WILSON, M.D...C-56.....*Tampa*

MEDICAL ECONOMICS

REUBEN B. CHRISMAN, JR., M.D., Chm...AL-53....*Miami*
JOHN E. MAINES, JR., M.D...B-53.....*Gainesville*
HARRISON A. WALKER, M.D...D-54.....*Miami*
WILLIAM H. WALTERS, JR., M.D...C-55.....*Lacoochee*
WILLIAM C. ROBERTS, M.D...A-56.....*Panama City*

VENEREAL DISEASE CONTROL

MELVIN M. SIMMONS, M.D., Chm...C-55.....*Sarasota*
JOHN R. BROWNING, M.D...AL-53.....*Jacksonville*
JOHN C. MCSWEEN, JR., M.D...A-53.....*Pensacola*
WILEY M. SAMS, M.D...D-54.....*Miami*
DAVID W. GODDARD, M.D...B-56.....*Daytona Beach*

TUBERCULOSIS AND PUBLIC HEALTH*

RALPH S. SAPPENFIELD, M.D., Chm...AL-53.....*Miami*
PHILLIP W. HORN, M.D...B-53.....*Jacksonville*
ERASMUS B. HARDEE, M.D...D-54.....*Vero Beach*
LOUIS J. GARCIA, M.D...C-55.....*Tampa*
HARRY S. HOWELL, M.D...A-56.....*Lake City*

*SPECIAL ASSIGNMENT

1. Diabetes Control

STATE CONTROLLED MEDICAL INSTITUTIONS

William D. Rogers, M.D., Chm...A-56....*Chattahoochee*
James L. Anderson, M.D...AL-53.....*Miami*
Bailey B. Sory, Jr., M.D...D-53.....*Palm Beach*
James G. Lyerly, M.D...B-54.....*Jacksonville*
Samuel G. Hibbs, M.D...C-55.....*Tampa*

MATERNAL WELFARE

E. Frank McCall, M.D., Chm...B-56.....*Jacksonville*
T. Bert Fletcher, Jr., M.D...AL-53.....*Tallahassee*
Lowrie W. Blake, M.D...C-53.....*Bradenton*
John N. Sims, Sr., M.D...A-54.....*Live Oak*
Ralph W. Jack, M.D...D-55.....*Miami*

CHILD HEALTH

Luther W. Holloway, M.D., Chm...B-53....*Jacksonville*
James R. Boulware, Jr., M.D...AL-53.....*Lakeland*
Warren W. Quillian, M.D...D-54.....*Coral Gables*
Daniel F. H. Murphey, M.D...C-55.....*St. Petersburg*
Courtland D. Whitaker, M.D...A-56.....*Marianna*

CONSERVATION OF VISION

Ralph N. Greene, Jr., M.D., Chm...AL-53..*Jacksonville*
William Y. Sayad, M.D...D-53.....*West Palm Beach*
Sherman B. Forbes, M.D...C-54.....*Tampa*
G. Taylor Gwathmey, M.D...B-55.....*Orlando*
Mozart A. Lischkoff, M.D...A-56.....*Pensacola*

ADVISORY TO WOMAN'S AUXILIARY

C. Robert DeArmas, M.D., Chm...B-55....*Daytona Beach*
Benjamin H. Sullivan, M.D...AL-53.....*St. Petersburg*
Edward F. Shaver, M.D...C-53.....*Tampa*
James L. Anderson, M.D...D-54.....*Miami*
Taylor W. Griffin, M.D...A-56.....*Quincy*

REPRESENTATIVES TO INDUSTRIAL COUNCIL*

Charles R. Burbacher, M.D., Chm...D-55..*Coral Gables*
Fred H. Albee, Jr., M.D...AL-53.....*Orlando*
G. Frederick Oetjen, M.D...B-53.....*Jacksonville*
Chas. L. Farrington, M.D...C-54.....*St. Petersburg*
Lee Sharp, M.D...A-56.....*Pensacola*

*SPECIAL ASSIGNMENT

1. *Industrial Health*

COUNCILOR DISTRICTS AND COUNCIL

Eugene G. Peek, Jr., M.D., Chm...AL-53.....*Ocala*
First—Francis M. Watson, M.D...1-54.....*Marianna*
Second—Benjamin A. Wilkinson, M.D..:2-53.*Tallahassee*
Third—William C. Thomas, Jr., M.D...3-54..*Gainesville*
Fourth—Eugene L. Jewett, M.D...4-53.....*Orlando*
Fifth—Hugh G. Reaves, M.D...5-53.....*Sarasota*
Sixth—Emmett E. Martin, M.D...6-54.....*Haines City*
Seventh—Erasmus B. Hardee, M.D...7-54....*Vero Beach*
Eighth—Donald W. Smith, M.D...8-53.....*Miami*

GRIEVANCE COMMITTEE

Walter C. Payne, M.D., Chm.....*Pensacola*
David R. Murphey, Jr., M.D.....*Tampa*
Herbert E. White, M.D.....*St. Augustine*
Joseph S. Stewart, M.D.....*Miami*
William C. Thomas, Sr., M.D.....*Gainesville*

ADVISORY TO SELECTIVE SERVICE FOR PHYSICIANS AND ALLIED SPECIALISTS

J. Rocher Chappell, M.D., Chm.....*Orlando*
Thomas H. Bates, M.D..."A".....*Lake City*
Frank L. Fort, M.D..."B".....*Jacksonville*
Alvin L. Mills, M.D..."C".....*St. Petersburg*
John D. Milton, M.D..."D".....*Miami*

EMERGENCY MEDICAL SERVICE

James V. Freeman, M.D., Chm.....*Jacksonville*
Merritt R. Clements, M.D..."A".....*Tallahassee*
Vernon A. Lockwood, M.D..."B".....*St. Augustine*
Herschel G. Cole, M.D..."C".....*Tampa*
Frederick K. Herpel, M.D..."D".....*West Palm Beach*

A.M.A. HOUSE OF DELEGATES

Homer L. Pearson, Jr., M.D., Delegate.....*Miami*
Frank D. Gray, M.D., Alternate.....*Orlando*
(Terms expire Dec. 31, 1952)

Louis M. Orr, II, M.D., Delegate.....*Orlando*
Joshua C. Dickinson, M.D., Alternate.....*Tampa*
(Terms expire Dec. 31, 1953)

Herbert L. Bryans, M.D., Delegate.....*Pensacola*
Thomas H. Bates, M. D., Alternate.....*Lake City*
(Terms expire Dec. 31, 1954)

BOARD OF PAST PRESIDENTS

William E. Ross, M.D., 1919.....*Jacksonville*
H. Marshall Taylor, M.D., 1923.....*Jacksonville*
John C. Vinson, M.D., 1924.....*Fort Myers*
John S. McEwan, M.D., 1925.....*Orlando.*
H. Mason Smith, M.D., 1926.....*Tampa*
John A. Simmons, M.D., 1927.....*Arcadia*
Frederick J. Waas, M.D., 1928.....*Jacksonville*
Julius C. Davis, M.D., 1930.....*Quincy*
William M. Rowlett, M.D., Chm., 1933.....*Tampa*
Homer L. Pearson, Jr., M.D., 1934.....*Miami*
Herbert L. Bryans, M.D., 1935.....*Pensacola*
Orion O. Feaster, M.D., 1936.....*Renton, Wash.*
Edward Jelks, M.D., 1937.....*Jacksonville*
W. Henry Spiers, M.D., 1938.....*Orlando*
Leigh F. Robinson, M.D., 1939.....*Fort Lauderdale*
Walter C. Jones, M.D., 1941.....*Miami*
Eugene G. Peek, Sr., M.D., 1943.....*Ocala*
John R. Boling, M.D., 1944, 1945.....*Tampa*
Shaler Richardson, M.D., 1946.....*Jacksonville*
William C. Thomas, Sr., M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne, M.D., 1949.....*Pensacola*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey, Jr., M.D., Sec'y., 1951.....*Tampa*

From Our President

A Holiday Message

Christmas persists. Despite the onslaught of the centuries, it comes again and again as surely as December. The fact is, Christmas will not down, and therein lies its profound significance.

"Glory to God in the Highest and on Earth peace to men of good will." Timeless in its setting, haunting in its beauty and universal in its implications, the sweetest story ever told crowds this earth again this month. To the millions who cherish a deep and searching heart hunger for peace in our time it offers renewed hope and strength.

Peace to men of good will — into that simple phrase are distilled the hopes and aspirations of all free men everywhere. Indeed, therein lies the only philosophy by which these desires can be consummated. The lesson of Bethlehem makes it clear that the difference in men's minds — is the difference in men's hearts. It is the exemplification of the good will of the Creator, the tangible evidence of God's love for all mankind.

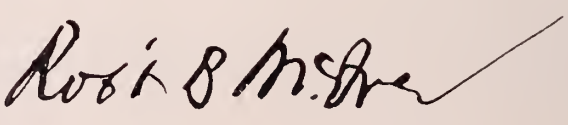
Men of every faith and every creed may take courage from the great symbolic feast of Christmas. Peace, on that first Christmas morning, came to dwell with men forever. Despite the hatreds and the conflicts across the centuries and the disillusionments of the present, the way to peace in our time remains at hand, awaiting only acceptance.

"Light looked down and beheld Darkness,
'Thither will I go,' said Light.
Peace looked down and beheld War.
'Thither will I go,' said Peace.
Love looked down and beheld Hatred,
'Thither will I go,' said Love.
So came Light and shone;
So came Peace, and gave rest;
So came Love, and brought Life,
And the Word was made Flesh, and dwelt among us."[1]

At this holy season we turn naturally to special thoughts of family, friends, pleasantries of the old year and hopes for the new. This festival of peace and love stimulates us to resolve anew to do our part in helping to restore to this troubled land those great principles on which our nation was founded and on which it has prospered.

Modern medicine in America has done much to uphold those principles and to make this holiday season a happier one for many. To the physicians who, with heart, hand and head, have made this contribution — greetings, and may the blessings of the Christmastide be yours.

1. By Laurence Housman. Reprinted from "God So Loved the World," edited by Elizabeth Goudge, New York, Coward-McCann, Inc.



The Journal of the
Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. BOX 1018 JACKSONVILLE, FLORIDA

Editor
Shaler Richardson, M.D.

Assistant Editors
Webster Merritt, M.D.
Franz H. Stewart, M.D.

Associate Editors
Louis M. Orr, II, M.D. Orlando
Joseph J. Lowenthal, M.D. Jacksonville
Jere W. Annis, M.D. Lakeland
Herschel G. Cale, M.D. Tampa
Wilson T. Sawder, M.D. Jacksonville
Carlos P. Lamar, M.D. Miami
Walter C. Payne, M.D. Pensacola

Managing Editor
Stewart G. Thompson, D.P.H.
Ernest R. Gibson, Asst.

Committee on Publication
Shaler Richardson, M.D., Chairman Jacksonville
Chas. J. Collins, M.D. Orlando
James N. Patterson, M.D. Tampa

Abstract Department
Kenneth A. Morris, M.D., Chairman Jacksonville
Walter C. Jones, M.D. Miami

Medical Men and Medical Events in British East Florida

From the earliest days of settlement there could be little doubt that St. Augustine was Spanish. The grey coquina homes with patios half hidden behind high garden walls and with balconies overhanging the quaint, narrow streets; the grim, massive, yet graceful walls of the fort, Castillo de San Marcos; the city gates; the shady public square or plaza, extending from the governor's mansion to the bay; the distinctive architecture of the churches; all were reminiscent of the charm that was Old Spain. Although the city was for some two decades the capital and sole town of British East Florida, its British inhabitants left virtually no impression on the culture and habits of the people.

England, after gaining possession of Cuba by force of arms, restored that island country to Spain and by a treaty signed in Paris in February 1763, received in return all Spanish possessions in the Floridas. During that year, 1763, practically the entire Spanish population left Florida. Among those departing were the "physician" of the presidio, Don Francisco Baraza; the "surgeon," Don Juan Bignon; and the "comptroller of the royal hospital," Don Pedro Horruitiner y Pueyo. British occupation of East Florida began almost immediately, but in spite of strenuous efforts to effect settlement of the land, occupation and growth at first proceeded very slowly. Apparently many Britishers did not approve of the trade. In a review of "Mr. Pitt's Administration" (London, 1763), the author, Mr. Almon, asked and answered the question: "What then did England gain by the honesty, the vigilance and wisdom of Mr. Pitt? Canada, an almost barren province; Florida, a sandy desert."

The first English civil governor of East Florida was James Grant. In 1763 he received his commission to serve at St. Augustine for seven years, but he did not arrive in East Florida until Aug. 29, 1764. Grant was greeted by the firing of guns in salute, but the usual festivities were lacking because of the small populace. His inauguration was delayed until the last day of October so that several persons he had invited to the colony could arrive and serve as members of his council. Among the distinguished members of the first council were John Moultrie and Robert Catherwood, both of whom were physicians. John Moultrie's father, Dr. John Moultrie, the eldest, had emigrated from Scotland in 1728 and had settled in Charleston. His son had received his M.D. degree from Edinburgh University in 1749 and had eloped in 1762 with Eleanor Austin, the daughter of a naval captain and merchant also of Charleston. She was his second wife. By her he had six children. The second son, James, followed the same career as his father and grandfather, was graduated in medicine at Edinburgh, returned to Charleston to practice

and continued the medical dynasty which still carries on the family profession.

Pleased with the climate, John Moultrie moved his family and Negroes to East Florida and became one of the largest planters in the territory. As many as 180 persons were employed and maintained on his lands. In 1771, he was appointed Lieutenant Governor, and when Grant left the territory for England that same year, he became acting Governor, serving in that capacity until 1774 when relieved by Governor Patrick Tonyn. Moultrie lived for 17 years in East Florida, but did not practice medicine.

View of the Governor's House at St. Augustine, November 1764. From Crown Collection of Photographs of American Maps, ser. 2, vol. 1, no. 41. The mansion, located at the head of the parade, is represented by the broad inverted L in block N on map of 1764.

Robert Catherwood, later a controversial figure, became a member of the first council in 1764 and, in addition, was made surgeon of the Royal Hospital that same year. He remained active in the territory for 18 years.

The Royal Hospital building stood on the west side of Hospital Street, now Aviles, about where the Artillery Lane Theater is located midway between King Street and Artillery Lane. This location was just south of the plaza or parade in the center of town where the principal public buildings stood. The hospital building was said to be larger than needed because the troops in Florida for the most part were healthy. It was described as "a very good airey hospital for 60 men."

In 1768, the British government underwent military reorganization in which St. Augustine became the station for three regiments and the headquarters of the Southern Brigade. Upon the arrival of Brigadier General Haldimand in April 1769, Governor Grant offered him the Indian Church building in exchange for that of the Royal Hospital for he wanted to convert the centrally located hospital building into a courthouse and a jail. The Indian Church had recently been completed by the Spaniards using Indian labor and was located less than half a mile north of the Castillo de San Marcos on the south side of Hospital Creek, as the accompanying map shows. The building was unique both in location and in architecture. It apparently occupied the location of Nombre de Dios, the site of the first mass said on territory within the present limits of the United States. North of this site across Hospital Creek Menendez is believed to have established the original St. Augustine, near the village of Seloy. John Bartram described the building in 1766, as follows:

> . . . y^{e} indian or milk church half A mile out of town is y^{e} compleates[t] piece of architecter about y^{e} town[.] at y^{e} gable end[,] according to y^{e} spanish tast[,] y^{e} collums is fluted[,] hath y^{e} capital & base & frize near y^{e} dorick order to y^{e} square[,] above which is A prodigious sight of carved stone according to thair fancy[.] it['s] strange y^{e} spaniards should bestow ten times more labour & charge on this indian church then any of thair own in y^{e} town[,] & as strange that A meer cluster of shells [,] whose vacances is not filled up with either sand or lime stone[,] but that A cluster of broken shells[,] confusedly tacked together by A cristaline spar[,] should be so fixed as to stand y^{e} chisel without flying to pieces or breaking farther then was designed[.]

General Haldimand agreed to the exchange of this building for that of the Royal Hospital. The removal of the patients and supplies to the Indian Church was finished by June 2, 1770. Because the terrace floor would rot the bedding in wet weather, Dr. Catherwood, as surgeon of the hospital in its new location, asked for 50 bedsteads. He stated

that as soon as certain additions to the building were made and wells were sunk, the hospital would be most comfortable.

The mildness and healthfulness of Florida's climate were recognized by Governor Grant during the early years of the English period for he frequently referred to it with pride. The year 1765 was apparently a year of widespread illness, but East Florida suffered much less than West Florida. In a letter to General Haldimand in Pensacola dated Oct. 3, 1768, Grant admitted that there was more sickness in East Florida that year than in 1765. He wrote:

> I was vastly happy to hear of the destination of the troops from West Florida, they will come in at a proper season of the year, our sickness which has been more considerable than ever was before in this province, will be over. The Disorders have been chiefly intermitting Fevers, without mortality. Our Phisical People impute the sickness to a remarkable rainy season. . . . I flatter myself that you will not dislike the change of Quarters, You will find everybody Friends and living sociably together . . . .a Town and a Province without the shadow of Factious Party or disputes. . . .

Bernard Romans, distinguished surveyor, botanist, cartographer and historian, in his famous and now rare "Natural History of East and West Florida," had much to say about the climate of East Florida, the health of its people, and his experiences with medical remedies used by local physicians and the Indians at that time. Some referred to him as "an enlightened physician," but so far as is known, he had no formal medical training. Commenting on the practices of the "Chactaws," Romans wrote:

> . . . While I was in this nation, i had the misfortune to be afflicted with a violent fever which ended in a flux; my own skill being baffled, i applied to my guide, who had the reputation of being a knowing physician well acquainted with the simples used among them. I submitted to his prescription; he got some herbs and roots, and made a decoction of them; i drank it, while the effect was expected, he alternately .burnt some of the simples and sat down by me blowing upon me to drive away the disorder; i found no benefit by it; and on my refusing another trial he said i was a fool, the next time the physic would be stronger, but he was not affronted. . . .
>
> In sickness the juggling Quacks are consulted and as they are naturally good connoisseurs in simples, and judge pretty well of the nature of diseases, they often succeed; but if a disorder is obstinate or incurable, the relations of the patient assemble in his house, bewail his misfortune, cry bitterly, take their leave of him, and he tells them how tired he is of life, that his misfortunes are unsufferable, and that it is good he should die; upon this an universal howl is raised, the nearest male relation jumps on him, and violently in a moment breaks the neck of the patient, and then they rejoice that his misery is over, but lamentations for his departure soon succeed.
>
> . . . Physick, or the knowledge of it, is another thing in which they pride themselves not a little, but they apply that name to all kinds of exorcisms, juggling and legerdemain tricks, as well as to the knowledge of diseases and the simples proper to cure them.

In these writings of Florida published in 1776, Romans observed of St. Augustine that "there is not a healthier place than this in this quarter. The inhabitants enjoy sound health, and reach great longevity, and invalids resort hither from Cuba, as to another Montpellier." He was firm "in dissuading all adventurers from coming hither, who are luxurious and intemperate, who are of a full habit or plethoric constitution, unless they can resolve to submit to a thorough change of regimen. Fevers prevail in July, August, and September and half of October, that is, immediately ensuing the heavy sultry rains. They are more obstinate in the low wet lands, where rice and indigo are cultivated." It was his opinion "that whenever the yellow fever has made its appearance in the Floridas, it was imported from Jamaica or Havana as was the case in 1765, which, by the way, was almost universally an unhealthy era, as well in Europe as elsewhere."

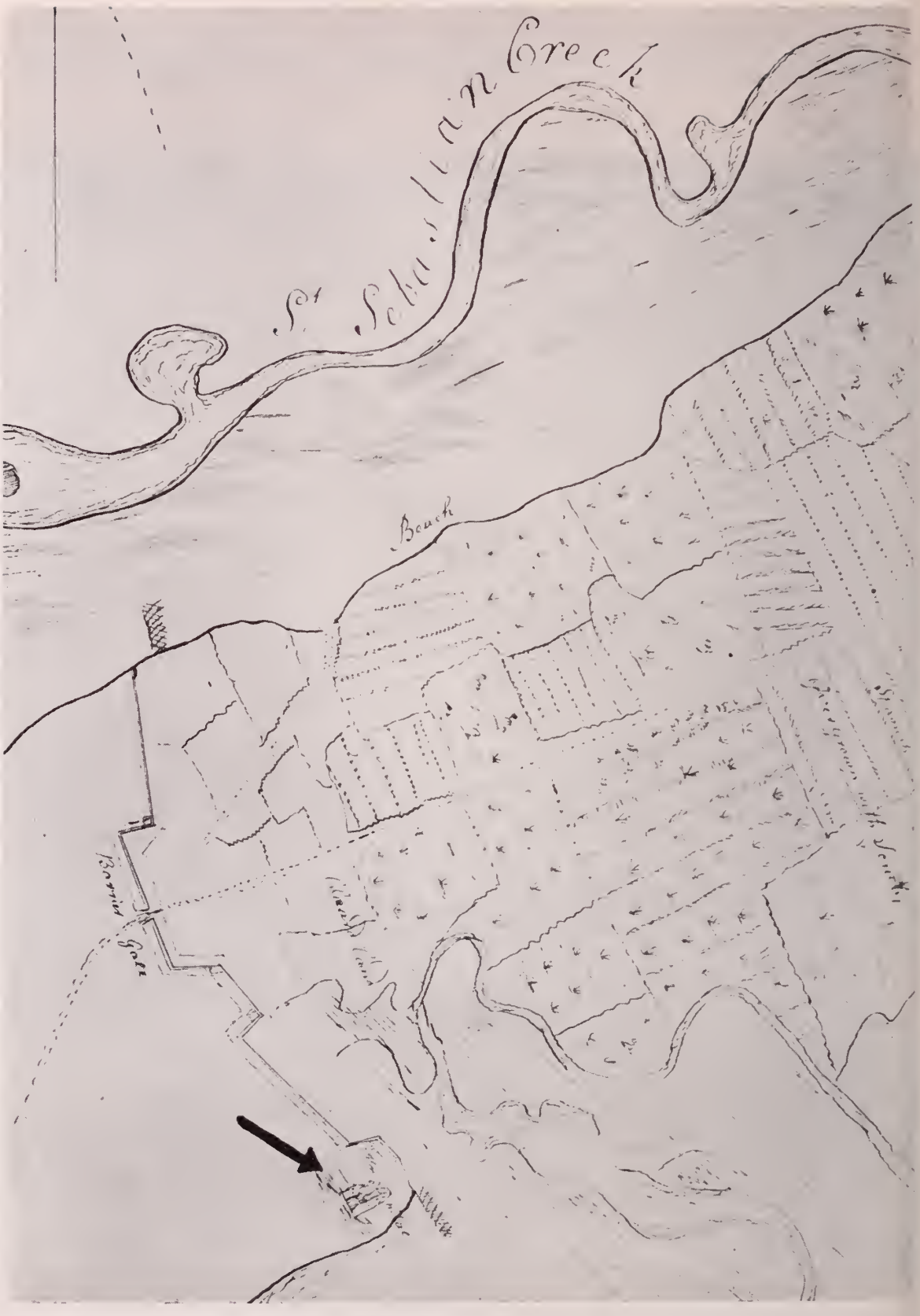
Dr. Andrew Turnbull's settlement of Minorcans, Greeks, and Italians at New Smyrna on Musketo Inlet approximately 60 miles south of St. Augustine is probably the most interesting and dramatic event of the British period. Dr. Turnbull was a prosperous Scottish physician who lived in London. He had spent several years in the Mediterranean countries and had married the daughter of a Greek merchant in Smyrna. It occurred to Dr. Turnbull that it might be practical to colonize Florida with people who were accustomed to a similar climate in the Old World. He selected those who supposedly were skilled in cultivating semitropical plants.

After obtaining financial support from friends whom he designated as partners, Turnbull selected his colonists chiefly from the British island of Minorca, but to some extent also from Leghorn and the Peloponnesos. During the spring of 1768, more than 1,400 persons sailed from Gibraltar in eight vessels under his protection. By early August they were established in New Smyrna, but hardly two weeks later serious trouble began between the Greeks and Italians wherein the storehouse was raided and an overseer was killed. The near riot which followed was quelled, the ringleaders were tried in St. Augustine, and two were executed.

The trials and hardships which the colonists

View of St. Augustine in 1764. The arrow indicates the site of the Spanish Royal Hospital, listed in the key to the map as "House of stone of the King which served as a Hospital." Its dimensions were 44 Spanish yards from

north to south by 51 Spanish yards from east to west. Produced from the photostat negative in the St. Augustine Historical Society Library. Original in the Library of Congress.



The Indian Church, which became the English Hospital in 1770, is indicated by the arrow. It was located three-tenths of an English mile north of the Castillo de San Marcos. Produced from the photostat negative in the St. Augustine Historical Society Library. Original in the Library of Congress.

underwent were severe. They established living quarters in huts that were hastily improvised. Their clothing was scanty, and they ate provisions which were quite inadequate. During the first year or so the mortality rate was reported to have been exceedingly high. Shortly after 1773, however, a visitor described the colony and its location as being a delightful and flourishing place with some 700 settlers. The annual indigo crop began to flourish.

Romans in his concise history later started the tradition that the Minorcans were found in a state of vassalage, given wretched meals in common messes, and forced to work in fields like Negroes under brutal overseers. Turnbull afterward contradicted these charges and stated that not only had he supported the colonists, but he also had given them and their descendants 99 year leases on land and produce.

The founder and the settlement fell under the animosity of Governor Tonyn. Some of the colonists who gave testimony that cruelties had been inflicted upon them and their families by the overseers were released from their indentures, while the remainder either deserted or were released by Turnbull's agents. Later all migrated to St. Augustine where they were given temporary living quarters north of the city. To this day the descendants of those colonists make up an important part of St. Augustine's population.

His friendship for William Drayton, chief justice of British East Florida, whose motives and loyalties remain an enigma, placed Turnbull in the "inflamed faction" Tonyn was determined to crush at all costs. After a long and bitter controversy with the Governor, he left for Charleston, where he later died. Recent research among Colonial Office documents has placed Turnbull in a more favorable light than did Romans and subsequent historians. New information from Spanish sources, however, tends to support charges of cruelty against him and his agents.

In addition to John Moultrie, Catherwood and Turnbull, another physician of the period was Richard Pritchard, the surgeon of the Ordnance branch of the military establishment. Too, there were the hospital mates of the military hospital, George Kemp and David Yeats. Serving also as register and deputy clerk of the Council, Yeats is credited with having a thriving private practice.

Councillor and judge as well as surgeon of the garrison, Catherwood, early in 1783, "was suspended from the position of judge of the court of vice admiralty for malfeasance, principally by taking extortionate fees under the denomination of fees of indulgence, at a time when the court was crowded with business." Replacing him was Dr. Lewis Johnston, formerly president of the council and treasurer in Georgia, who was appointed assistant judge and a member of the council. The sequel to this unfortunate turn in Catherwood's affairs is revealed in a notice published in The East-Florida Gazette in February 1783:

> All persons having demands against the subscriber, on either his private account or that of his Majesty's Hospital, under his direction are desired to bring in the same and receive payment and requests those who are indebted to him, by bond, note, book account or otherwise to discharge same.
>
> He will dispose of at private sale, some valuable Tracts of Land on St. Johns River and at known by the name of Rains Cowpen Creek. For particulars apply to
>
> Robert Catherwood
> Surgeon, G. H.

This item appeared in one of the earliest issues of the first newspaper ever published in East Florida. A physician, Dr. William Charles Wells, about Feb. 1, 1783, began publication in St. Augustine of this weekly newspaper, The East-Florida Gazette, and continued to publish it until his brother arrived from England in the spring of 1784 to take it over. Son of a bookseller and bookbinder who published a newspaper in Charleston, Wells was born there in 1757. After loyalist difficulties had caused his father to return to England in 1775, he soon followed for similar reasons. He then studied medicine in Edinburgh and London before returning to Charleston in 1781, where his brother John was now issuing the newspaper as a patriot journal. Persuading his brother to return to England to seek reconciliation with their father, Wells edited the paper as a loyalist organ, and when he joined the royalist exodus to St. Augustine in December 1782, his printing press and a pressman sailed with him. Upon finding that the pressman could not reassemble the parts of the press, by studying a printer's grammar among his book he eventually put it in order with the aid of a Negro carpenter. A facsimile of the first page of the earliest copy of his East-Florida Gazette known to be extant is here reproduced.

Dr. Wells later returned to Charleston under a flag of truce to attend to business for his father's family, but was nevertheless imprisoned for three months. Governor Tonyn sent a commissioner to demand his release, and when he was finally allowed to set sail for St. Augustine, he narrowly

VOL. I. THE No. 5.

East-Florida GAZETTE.

NULLIUS ADDICTUS JURARE IN VERBA MAGISTRI. Hor.

From SATURDAY, FEBRUARY 22, to SATURDAY, MARCH 1, 1783.

POLICE OFFICE.

WHEREAS frequent riots and other disorders have happened in this province, and particularly in the town of St. Augustine, for want of regulations and restrictions in keeping taverns, punch-houses and retailing of spirituous liquors, whereby the peace and good government of the province has been disturbed, and the morals of many of the people have been corrupted; for remedy whereof, as much as may be, the General Assembly by an Act passed the 11th day of January last, directs, that no person or persons shall sell any beer, cyder, brandy, rum, punch, shrub or other strong liquors whatsoever, (except wine, where a licence is obtained for retailing the same) in less quantities than two gallons at one time, and to one person, or keep any skittle alley, shuffle-board, bill and table, or any other publick playing place, until he, she, or they shall have first obtained a licence, or licences from the Treasurer, under the forfeiture and penalty of ten pounds sterling for every offence, one half to the informer, and the other in aid of the general tax.

If any person not having a licence shall sell or dispose of on credit any spirituous liquor in less quantities than two gallons at one time to any one person, the same shall be forfeited and lost, nor shall the person so credited or trusted be liable to any suit on that account.

Persons obtaining licence to keep a tavern, punch-house, victualling house, or house of accommodation for the entertainment of strangers or to retail spirituous liquors in the town of St. Augustine, or within four miles thereof, shall pay five pounds, and for other parts of the province two pounds; for keeping a skittle alley twenty pounds, a shuffle board twenty pound, a bill and table thirty pounds; and for any other such gaming place ten pounds, all which licences shall continue in force one year only; the fifth and qualification of persons who apply for licences to be certified by two or more Justices of the Peace.

If any person shall barter, exchange, give or lend any spirituous liquors or strong drink by any deceitful ways and means, in order to evade the intentions of the Act, not having a licence, or having a licence shall retail liquors to slaves (not having tickets) or to any Indian, or barter in exchange for the same with goods of any kind from a soldier, sailor, indented servant, or Indian slave, the offender shall pay a fine of ten pounds.

Profane cursing or swearing any mariner belonging to any vessel in this province, having signed the ship's articles, a sum exceeding five shillings, (except by leave of the master) shall forfeit the money or goods so credited or trusted, and if such mariner be harboured or kept by any person, in his or her house, the offender shall forfeit the sum of two shillings for every hour he is so harboured.

Keepers of taverns or tippling houses, or any other person who shall sell spirituous liquor mixed or otherwise to any wicked mariner to the amount of more than one shilling and sixpence in one day, or to entertain, or suffer him to remain in his or her house to drink or tipple therein after nine o'clock at night, unless by leave of the master) shall forfeit the sum of twenty shillings.

If any person or persons keeping or attending any ferry shall wittingly or willfully transport or suffer to be transported over such ferry, any fugitive seaman or soldier not having a certificate of his discharge, or a written pass from his officer, shall forfeit five pounds.

The Governour or Commander in chief for the time being is by the said Act authorised to empower Commissioners to grant licences to such persons as they shall think fit, to sell any kind of wines in less quantities than three gallons, to be drunk and spent within the house of the party so licenced; and such commissioners shall take for every licence the sum of three pounds, where such person has not a licence for retailing spirituous liquors; and where a person has such licence the sum of two pounds; and if any one shall presume to sell any kind of wines in less quantities than three gallons, without having first obtained such licence, every person so offending shall forfeit and pay the sum of twenty pounds sterling.

To the end therefore that so useful and salutary a law may be strictly obeyed, if any person shall be convicted of the least breach thereof before the senior Justice, the party offending will be proceeded against with the utmost rigour by the said Act prescribed.

ASSIZE of BREAD.

FORASMUCH as the inhabitants of the town of St. Augustine, have been and yet are aggrieved and subjected to great and many inconveniences for want of some wholesome restrictions on the bakers of bread for sale, with regard to the quality, weight, price and assize of an article so essentially necessary to their health and support; and whereas evil disposed persons have taken the advantage for their own unlawful gain and lucre to deceive and defraud his Majesty's subjects, and more especially the poor, being thereby greatly distressed: The legislature of this province, for remedy in future of a practice so encreasing and oppressive, has required the several Justices, upon the best information he can get, to make publick once in every month or oftener if he shall think necessary, the ordinary or market price of flour, which shall be taken and deemed the market price from time to time of such flour, for one month after such publication, and also to let forth the several assized weights of each of the sizes of bread, that is to say; then when flour is at the rate of fifty shillings per one hundred weight, the sixpenny loaf shall weigh one pound averdupois (sixteen ounces) and the other sizes in proportion, diminishing or encreasing the weight of the said loaves according as the flour rises or falls, and according to the aforesaid proportion.

I have therefore enquired what is the present ordinary or market price of flour this day, and find it to be twenty-five shillings the hundred weight, so that for one month from the date hereof, the three-penny loaf is to weigh one pound, the sixpenny loaf is to weigh two pounds, and the shilling loaf is to weigh four pounds, to be made of good wholesome wheaten flour, without any mixture other than what shall be necessary to the well making or baking thereof, to be judged of by the Magistrate trying and examining the same.

And every baker or other person making bread for sale, or exposing the same for sale, must mark or imprint, or cause to be fairly marked or imprinted on every loaf, so by him or her made, the price of such loaf, together with the initial letters of his or her Christian name, and surname at length, that the baker and price thereof may be more distinctly known.

The Justices, Churchwardens, or Vestrymen, may in the day time enter into any house, shop, stall, bake-house, or ware-house, of or belonging to any baker or seller of bread, and there search for, view, try and weigh all and any bread of such person or persons, which shall be there found, and they may enquire into and determine all complaints concerning the above offences; and if any such bread so found shall be wanting either in goodness of its materials, or not duly baked, or wanting in its due weight, as by this assize is set, or not marked as aforesaid, or shall be computed of or made up with any other materials than what are by the Act allowed, then and in every such case it shall be lawful for the Justices, Churchwardens or Vestry, or any two of them, to seize and take the bread so found, and cause the same to be given and distributed to the poor of the district where such seizure shall be made, and also to impose a fine on any baker or seller of bread so offending a sum not exceeding five shillings, nor less than one shilling for every loaf so found deficient and seized; and if any person whatsoever shall not permit or suffer such search or seizure to be made, or shall oppose, hinder, obstruct or resist the same, he, she or they so doing shall for every such offence forfeit the sum of twenty pounds sterling.

SAMUEL PARLEY,
Police Office, Feb. 25, 1783. Senior Justice.

(BY PERMISSION)

On MONDAY, Evening the 3d of March,
WILL BE PRESENTED,
At the THEATRE,
In the STATE-HOUSE,
The BEAUX STRATAGEM,
A COMEDY,
To which will be added,
The ENTERTAINMENT of
MISS IN HER TEENS,
The Characters by Gentlemen, for the benefit of the distressed *Refugees.*
Doors to be opened at SIX o'clock; Performance to commence at SEVEN; no money taken at the door.
Tickets to be had at Mr. JOHNSTON's store, formerly Mr. Payne's.
PIT, 5s. 9d. GALLERY, 4s. 6d.

WHEREAS the senior officer of his Britannick Majesty's ships and vessels of war, at the port of Charlestown, having thought proper to transfer the appointment of Commissary for naval prisoners for the southern district, to St. Augustine, East-Florida: all commanders of privateers, letters of marque, armed vessels of every denomination, and prize masters are hereby directed, that in future they do report and deliver their naval prisoners, at the Commissary for naval prisoners office, St. Augustine.

Given under my hand and seal of office, at St. Augustine, East-Florida, this 28th day of February, one thousand seven hundred and eighty three.

CHARLES PRINCE, Commissary
Naval Prisoners Southern District.
By order of the Senior Officer.

EAST-FLORIDA, *St. Augustine, February 26, 1783.*

Wanted to Charter,

FOR Government use, a VESSEL of about one hundred and forty tons burthen, well breathed, and in every respect fitted for a naval prison ship. Any persons willing to furnish a vessel answering the above description, are to give in their proposals at St. Augustine, to Lieutenant CHARLES PRINCE, Commissary of naval prisoners or to

JAMES FRASER.

To be sold and possessed the greatest part of the Premises immediately given,

THAT excellent HOUSE and LOTT, on the Bay, known by the name of Dennis's Quarter, pleasantly situated for a private family, and equally well for either wholesale or retail business as at present owned and occupied by JAMES WALLACE, to whom any one intending to purchase may apply.

The premises are extensive and well suited with back store, kitchen, stable, &c. and room for further improvement.

TO BE SOLD,
A light, dirty
POST COACH,
With harness compleat for a pair of horses.
Enquire of the Printer.

Facsimile of a front page of Florida's first newspaper, published in St. Augustine in 1783 by William Charles Wells, M.D. This is the earliest issue extant. Original in the Public Record Office, London.

escaped death by shipwreck. After the arrival of his brother, he returned to England in May 1784. Once apprenticed to Charleston's "chief practitioner of physic" and famous naturalist, Dr. Alexander Garden, Wells became famous in London as a physician and natural scientist and was honored in 1816, the year before his death, by the Royal Society, of which he was a Fellow.

In June 1784, one month after Wells' departure for England, Governor Zespedes arrived in St. Augustine with the officers of the Spanish civil and military departments and a small body of soldiers. The English evacuation was nearing completion, and East Florida was once again under Spanish rule.

Jingle Bells

Christmas gift, Doctor! This December the Editors of The Journal are falling in with the popular custom of presenting their own Christmas list to see what comes of it. Here is what they would like for Christmas — and throughout the coming year, for that matter.

A goodly number of topflight new manuscripts heads the list. The original manuscripts, they mean, not carbon copies, of scientific articles containing from 1,000 to 4,000 words each, carefully typed with double or triple spacing, even to case reports, references and footnotes, and on a typewriter with a fresh ribbon. Too, the references should be only the pertinent ones and complete in form, for, as has been aptly said, the only impression inflated "bibliographies" make is a bad one.

"Needless to say, perhaps," writes a fellow editor with whose comments we heartily agree, "any paper that is fit to be published is written in as good English as the author can muster and is then rewritten at least twice, with a number of words discarded at each writing; for anything that is worth saying at all is usually said twice as well in half the number of words. Its tables and charts are few and simple and properly captioned. In its final state it is crystal clear and informative and meets some need other than that of the author for publicity.

"After all, the only really valid reason for writing a scientific medical article is to present the results of useful investigation or seasoned experience, thus adding to the sum of medical knowledge, or to bring together and correlate existing knowledge in order to make it more easily available. Only occasionally is a single case worth reporting, to remind a journal's readers of the existence of some conditions that may cause diagnostic confusion or to add to the knowledge of its treatment; it should be reported with the utmost brevity. A case report should always point a moral, whether or not it may adorn a tale."[1]

In addition to a wealth of carefully prepared scientific papers from which to choose, the Editors modestly add to their list a series of inspired and timely editorials, medical news items and commentaries as nearly current as possible, strict observance of deadlines, a growing list of contented advertisers and an expanding circulation.

Finding these gifts in their stockings, the Editors during the year ahead will send every member of the Association a brand new copy of The Journal every month which will be a year-round Christmas present engendering pride and quickened interest. Inevitably, The Journal can be no better than the members make it, no matter how attractive its format.

Jingle bells, Jingle bells, Jingle all the way! Come Christmas, Doctor, remember the Editors and prove to them that there really is a Santa Claus.

1. Editorial: New England J. Med. 245:988 (Dec. 20) 1951.

Training in the Care of the Injured

Whatever their field, all physicians meet the problems of injury with more or less frequence. Trauma, with all its attendant involvements, is an ever present problem of this mechanical age which promises only to increase.

During 1951, the National Safety Council reports, 93,000 persons were killed in accidents in this country and 9,100,000 more were injured. Some 4,000,000 met with home accidents, 2,000,000 with public nonoccupational, nonmotor vehicle accidents, 2,000,000 with occupational accidents and 1,300,000 with motor accidents. Eight billion dollars was the estimated economic loss from these accidents, of which the medical cost was about one-half billion. One of every 17 persons in the United States suffered a disabling injury in 1951. With the final holiday season of 1952 approaching, it is not pleasant to contemplate the record for this year, which, judging from incomplete figures, may well exceed that of last year.

It is the general practitioner who usually treats the injured first, and it is he who cares for most of these patients until they recover. He should do so, of course, but this responsibility falling upon him calls for wide publicizing of the new concepts

of treatment if they are to have general use. Furthermore, only a broad appreciation of how the best results may be obtained enables the general practitioner to recognize when early referral to a specialist may mean saving life or limb or preventing permanent disability. By more effective early or definitive care, doubtless many of the 250,000 persons suffering permanent disability annually could be spared that fate.

Recently, in a foreword to a symposium on trauma, Dr. Robert H. Kennedy directed attention to the little time devoted to instruction in trauma in medical schools with the usually slight attention varying in different departments according to the interest of the instructor. For meeting this problem that cuts across every field of medicine just as cancer does, this professor of clinical surgery of New York University Post-Graduate Medical School expressed the hope that some day there will be coordinators similar to those established by the United States Public Health Service for cancer.

He also observed that in many hospitals, even though a considerable percentage of the admissions may result from accidents, little attention is paid to instructing the house staff in traumatic problems. "The emergency room," he commented, "is frequently handled by the most inexperienced intern, whereas the problems arising there for immediate settlement are often the gravest. Many attending surgeons have no idea what goes on in their emergency rooms. They are losing the greatest opportunity to teach to the future practitioner the intricacies of handling asphyxia, shock, and hemorrhage. . . . The interns and residents, who will derive most of their livelihood for some years after they are in practice by treating injured people, need guidance in such efforts more than in complicated surgical procedures."[1] In view of the rising accident rate, it would seem especially advantageous to make the most of this opportunity for instruction.

It is upon postgraduate medical education that the heaviest responsibility rests today for meeting the need for training in the care of the injured. Here lies the broadest opportunity to save life following trauma, to prevent many permanent disabilities, to shorten morbidity and to make many persons more comfortable during recovery from injury. On many a scientific program this timely subject bids for a place.

1. Kennedy, R. H.: Symposium on Trauma, Foreword, Modern Medicine 20:65-67 (Sept. 1) 1952.

Placement Assistance for Physicians

A program recently undertaken by the American Medical Association has won the enthusiastic endorsement of state medical societies and chairmen of Selective Service Medical Advisory Committees. Its purpose is to acquaint physicians leaving military service with existing medical opportunities, and to assist State Selective Service Medical Advisory Committees in replacing deferred physicians classified as Priority 1 under the "Doctor Draft Law."

The Council on National Emergency Medical Service of the American Medical Association inaugurated this program with the cooperation of the Department of Defense and the Selective Service System. The council will receive from the offices of the three surgeons general the names of physicians to be released from service and other necessary information. It will then communicate with each of these physicians to determine, in general, his postservice plans, his medical qualifications and specialty, and also the state in which he prefers to work.

After being broken down by states, the names of physicians interested in receiving additional information will be sent to State Selective Service Medical Advisory Committees. The names will be forwarded primarily as potential replacements for deferred Priority 1 physicians; further action, however, if any, with respect to them will depend entirely on the wishes and desires of the advisory committees.

This information will likewise be made available to state medical societies through the Physicians' Placement Service of the A.M.A. Council on Medical Service in accordance with current procedures.

This new program should render valuable assistance to individual physicians and to state medical societies. It will no doubt be successful in placing satisfactorily many physicians upon their release from active duty.

"How Sick Is Socialized Medicine?"

It has been aptly said that "our fight is against the malignancy of Socialism, not merely socialized medicine," if the free world is to survive. Since malignancy is defined not alone as the quality of being malignant, virulent or life-threatening but also as a tendency to increase in virulence, certainly socialized medicine in practice offers a timely example of socialism's progressively virulent nature. What impartial observer can gainsay that it

is truly malignant in that it tends to go from bad to worse?

A recent survey of Britain's national health scheme by Melchior Palyi, noted economist, reveals its result as the depressing opposite of its glowing promises. Less than three years after the program became law in Britain, 553,577 persons were on the waiting list for hospital beds. Many of the mentally deficient and the helpless aged have been deprived of institutional care and are left to shift for themselves. In four years, the costs of governmentalized medicine have almost trebled, mounting to more than 10 per cent of the overinflated national budget.

The something-for-nothing Utopia, advertised worldwide, is now in slow retreat. Socialism or no socialism, the people are finding that they actually pay for what they get "free." "First class" treatment is open primarily to those who can afford to pay. It seems astounding from the sheer physical feat involved, let alone the professional aspects, that fewer than 20,000 general practitioners carry the main burden of medical care for more than 45,000,000 people. In industrial medicine there is no progress at all.

"How Sick Is Socialized Medicine?" This title of Mr. Palyi's excellent magazine article[1] is a timely question worthy of careful consideration. Physicians and laity alike need to be well informed on the subject. Britain's health program offers a notable example of the malignancy of socialism and affords an excellent illustration of the pitfalls which await this country if it continues its disastrous socialistic trend.

1. Palyi, M.: How Sick Is Socialized Medicine? The Freeman (June 16) 1952. Reprints at $7 a hundred or $60 a thousand may be obtained from The Freeman, Dept. PB, 240 Madison Ave, New York 16, N. Y.

Midwinter Seminar in Ophthalmology and Otolaryngology Miami Beach, Jan. 12-17, 1953

For the seventh successive year, the annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held in Miami Beach, opening on January 12 and continuing through January 17. The Sans Souci Hotel will be headquarters.

The lectures on Ophthalmology are scheduled for January 12, 13 and 14. The distinguished ophthalmologists presenting them and their subjects are: Dr. Walter S. Atkinson, Watertown, N. Y., "Preanesthetic Preparation of the Patient," "Anesthesia in Ophthalmology," and "Measures Which Decrease Operative Accidents;" Dr. Charles E. Iliff, Baltimore, "The Diagnosis and Treatment of Lesions of the Limbus," "The Diagnosis and Treatment of Tumors of the Lids," and "Dacryocystorhinostomy;" Dr. Brittain F. Payne, New York City, "Modern Trends in Cataract Surgery," "Granulomata of the Eye," and "Pathologic Studies in Acute and Chronic Glaucoma;" Dr. Lawrence T. Post, St. Louis, "Practical Analysis of Strabismus Cases," "Postoperative Complications of Cataract Surgery with Special Reference to Secondary Glaucoma," and "Diagnosis and Treatment of Chronic Simple Glaucoma;" and Dr. I. S. Tassman, Philadelphia, "The Retinopathy in Diabetics," "Fundus Lesions in Diseases of the Vascular System," and "The Eyes and the Autonomic Nervous System."

On January 15, 16 and 17 the lectures on Otolaryngology will be presented. The noted medical teachers in this specialty and their subjects are: Dr. A. C. Furstenberg, Ann Arbor, Mich., "Diseases of the Salivary Glands," "Neurological Conditions of Practical Importance to the Otolaryngologist," and "The Treatment of Nasal Obstruction;" Dr. Victor Goodhill, Los Angeles, "New Testing Technics in Pediatric Deafness," "The Differential Diagnosis of Tinnitus and Its Management," and "Exploratory Mastoidectomy in Atticotympanic Disease;" Dr. Frank D. Lathrop, Boston, "Affections of the Facial Nerve," "Tumors of the Head and Neck," and "Head Pain;" Dr. Samuel Salinger, Chicago, "Treatment of Trauma to the Face; Primary and Secondary Therapy," "Routine Rhinoplastic Procedures," and "Nasal Implants; Evolution in Procedures;" and Dr. Theodore E. Walsh, St. Louis, "What Can Be Done for the Hard of Hearing?" "Vasomotor Rhinititis," and "Management of Menière's Disease."

The Florida Society of Ophthalmology and Otolaryngology will entertain on Wednesday evening, January 14, preceding its midwinter convention. Eminent speakers will present the scientific program at this annual meeting, held concurrently with the Seminar.

The Editor Invites Your Contributions on Data of Notable Interest

---

Graduate Medical Education

The Duval Heart Association is the name of the recently reorganized heart association of Duval County, which will now include the counties in Northeast Florida. A cardiac clinic has been established at the Duval Medical Center where weekly clinics will be held. As soon as satisfactory arrangements are made, cardiac patients from the counties included in this area will be cared for at the clinic.

Physicians in this area desiring special training in cardiovascular diseases, on application to the Chief of the Medical Service of the Duval Medical Center, Jacksonville, will be assigned to this clinic on a rotating basis. Physicians will be allowed the privilege of attending as observers.

* * *

An organizational meeting for the Florida Diabetic Association was held in Orlando on Oct. 5, 1952. It is anticipated that each component society of the Florida Medical Association will have representatives in this association. Education of physicians in the treatment and the handling of the diabetic patient and the dissemination of knowledge to the laity on the subject of diabetes mellitus are two of its principal objectives.

The annual meeting is to be held at the time of the Diabetic Seminar each spring. It is planned to have the first annual meeting with the Diabetic Seminar in St. Petersburg early in May 1953.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Jacob Kaufman of Miami announce the birth of a daughter, Stephanie, on Aug. 26, 1952.

Dr. and Mrs. David Kirsh of Miami announce the birth of a daughter, Carol Ann, on Aug. 26, 1952.

Dr. and Mrs. Charles L. Shalloway of Hialeah announce the birth of a son, Mark Alan, on Sept. 24, 1952.

Dr. and Mrs. Carlos P. Lamar of Miami announce the birth of a daughter, Carmencita, on Oct. 7, 1952.

Dr. and Mrs. William P. Blackmon of Mayo announce the birth of a son, Robert Scott, on Oct. 9, 1952.

Dr. and Mrs. Frank H. Lindeman, Jr., of Tampa announce the birth of a daughter, Frances Ann, on Oct. 15, 1952.

Deaths — Members

Petteway, Charles H., Lakeland ..... Sept. 27, 1952
Anderson, James M., Cross City ..... Oct. 5, 1952
Kay, Milton B., Miami Beach ..... Oct. 13, 1952

Deaths — Other Doctors

Scurry, B. C., (Col.), Cocoa ..... May 20, 1952
Pearson, Richard J., Tampa ..... Oct. 25, 1952

New Orleans Graduate Medical Assembly

The sixteenth annual meeting of The New Orleans Graduate Medical Assembly will be held March 2-5, 1953, headquarters at the Municipal Auditorium.

Eighteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. In addition, the program will include a symposium on "The Value of Newer Drugs," daily demonstrations of medical and surgical procedures in color television, clinicopathologic conferences, medical motion pictures, over 100 technical exhibits and three roundtable luncheons.

The Assembly has planned another interesting postclinical tour to follow the 1953 meeting in New Orleans. On Saturday, March 7, a party composed of doctors and their families will leave New York for Europe on the great new superliner, S. S. United States. The itinerary includes England, France, Switzerland and Italy, and arrangements have been made for medical programs in these countries. The tour ends in Rome and the group will return to New York on March 31 by Pan American World Airways, President Special.

Details of the New Orleans meeting and the postclinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

Medical Officers Returned

Dr. I. Irving Weintraub, who entered military service on Aug. 29, 1950, was released from active duty on Sept. 30, 1952 with the rank of Major (U. S. Army). His address is Box 217, Gainesville.

Dr. H. Lamar Boese, who entered military service on Jan. 6, 1951, was released from active duty on Aug. 3, 1952. His address is 121 Rose Drive, Fort Lauderdale.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Boyd, Jack L., Chattahoochee
Kaufman, Jacob, Miami
Rorebeck, Curtis C., Tampa
Weeks, Theodore W., Jr., Tallahassee

STATE NEWS ITEMS

Dr. Robert B. McIver, Jacksonville, Association president, delivered the address of welcome at the Forty-Sixth Annual Session of the Southern Medical Association, Miami, November 10-13.

Featured speakers at the recent meeting of the professional staff of the Florida Council for the Blind in Tampa included Drs. Sherman B. Forbes, administrative medical consultant, and J. Robert Campbell, psychiatrist, both of Tampa.

Dr. Harrison G. Palmer of St. Petersburg has returned to his practice after attending the Michigan State Medical Convention in Detroit.

Dr. Hawley H. Seiler of Tampa has been appointed a member of the National Advisory Board of the American Trudeau Society.

The following members of the Association recently attended postgraduate courses at the Cook County Graduate School of Medicine in Chicago: Drs. Samuel J. Simmons, Jr., of Belle Glade; Amsie H. Lisenby of Panama City; I. Irving Weintraub of Gainesville, and DeWitt C. Daughtry of Miami.

Dr. Peritz Scheinberg of Miami spoke at a meeting of the Miami Multiple Sclerosis Association recently. Dr. Scheinberg is head of the Association's medical advisory board.

Dr. Chester L. Nayfield of Lakeland, Director of the Polk County Health Department, spoke at a recent meeting of the Rotary Club of Winter Haven.

Physicians from Florida, Georgia and South Carolina met at Daytona Beach with the Maternal Welfare Committee of the Association and Bureaus of Maternal and Child Health departments of the three states on September 8. The Volusia County Medical Society was host to the meeting.

Dr. George F. Schmitt, Jr., of Miami was the recent guest speaker of the Rotary Club of Key West. His topic was the heart.

Mr. Harold Parham on October 15 resumed his position as supervisor of the Bureau of Public Relations following a tour of active military duty with the Far East Command. Lt. Parham was stationed in Tokyo prior to his release to inactive duty.

Dr. Homer L. Pearson, Jr., of Miami attended the assembly of the World Medical Association in Athens, Greece, in October as a representative of the American Medical Association.

Dr. Charles McD. Harris, Jr., of West Palm Beach spoke on "Recent Advances in Gynecology," before the Good Samaritan Nurses Alumnae Association in October.

Dr. Ashbel C. Williams of Jacksonville was re-elected president of the Florida Division of the American Cancer Society at a meeting in Daytona Beach. Dr. Donald H. Gahagen of Fort Lauderdale was elected first vice president, and Dr. David R. Murphey, Jr., of Tampa was elected third vice president.

Dr. Percy L. Dodge of Miami spoke on "Florida, the Land of Enchantment, and Miami, the Magic City" before the Veterans of Foreign Wars at Meredith Center, N. H., recently.

Dr. Ralph W. Jack of Miami was among the guest speakers at the recent meeting of the Florida Association of Accident and Health Underwriters at the Shore Club Hotel, Miami Beach.

Dr. Frederick K. Herpel of West Palm Beach, president-elect of the Association, has returned to his practice following a visit to California and other western states. Dr. Herpel visited clinics and hospitals in various western cities.

During the next few weeks Dr. Herpel will give serious study to the selection of chairmen of standing committees and other committee appointments.

Dr. John F. Lovejoy of Jacksonville was the guest speaker at a recent luncheon meeting of the Fernandina Lions Club. Dr. Lovejoy spoke on the progress made in medicine during the past few years and told of some of the work carried on at Hope Haven Hospital in Jacksonville.

Dr. J. Basil Hall of Mount Dora spoke on "Are We Up and Atom," at a recent meeting of the Junior Chamber of Commerce of that city.

Dr. Samuel G. Hibbs of Tampa was guest speaker at a recent luncheon meeting of the Tampa Rotary Club.

Dr. John S. Cowdery of Jacksonville has been recalled to active duty with the U. S. Naval Reserves.

Dr. Arthur L. Juers of Miami gave a paper on "Modified Radical Mastoidectomy" at the meeting of the American College of Surgeons in New York City in September. Dr. Juers also recently attended the annual meeting of the American Academy of Ophthalmology and Otolaryngology in Chicago where he gave an instruction course on hearing aids.

Dr. Harry M. Edwards of Ocala was assisted by Drs. Bertrand F. Drake, Richard C. Cumming and William H. Turnley, all of Ocala, in presenting a program on cancer at a recent luncheon meeting of the Rotary Club of that city. A film entitled, "The Doctor Speaks His Mind," was shown.

Dr. J. Maxey Dell, Jr., of Gainesville presented a scientific exhibit on a new technic for demonstrating the internal auditory canals and the clinoid processes at the Fifty-third Annual Meeting of the American Roentgen Ray Society in Houston, Tex., in September.

Dr. Luther W. Holloway of Jacksonville attended the sessions of the Georgia Pediatric Society held in Atlanta in October.

Dr. Clarence D. Rollins of Jacksonville attended the Postgraduate Course for General Practitioners held in Atlanta in October under the auspices of the Emory University School of Medicine, the Medical Association of Georgia and the Georgia Chapter of the American Academy of General Practice.

Dr. Max Pepper of Miami has returned to his practice after attending the Second International Congress of Internal Medicine in London.

Dr. Millard B. White of Sarasota was speaker at a recent meeting of the Licensed Practical Nurses Association of Manatee County.

Dr. James R. Nieder of Delray Beach presented a motion picture entitled, "Cataract Extraction by Erisophake," during the annual course of the Chicago Eye, Ear, Nose and Throat College which preceded the meeting of the American Academy of Ophthalmology and Otolaryngology in October. The motion picture was filmed at the Nieder-Robinson Clinic in Delray Beach.

An Institute on Cardiology was sponsored recently in the Miami Public Library by the Private Duty Section of the Fifth District, Florida State Nurses Association. Speakers included Drs. George F. Schmitt, Jr., Edwin P. Preston, Nicholas A. Tierney, Herbert Eichert and DeWitt C. Daughtry, all of Miami, and Dr. Earl R. Templeton of Miami Beach.

Dr. Edward R. Annis of Miami spoke on "Doctors as Citizens" at the Marquette Alumnae Annual Meeting in Milwaukee in October. He was also the honored guest at a banquet of the Wisconsin State Medical Society while there.

Dr. Sherman R. Kaplan of Miami spoke on "Understanding Anemias" at the regular monthly meeting of the Florida Society of Medical Technologists, Miami Chapter, on October 21.

Dr. Julian D. Parker of Stuart, who is retiring due to failing health, was honored recently by the townspeople with a reception and a shower of silver. Dr. Parker has cared for the sick in Martin County for 27 years and delivered more than half of the county's 8,000 population.

Dr. James N. Patterson of Tampa, while attending the meetings at the College of American Pathologists and the American Society of Clinical Pathologists in Chicago recently, was nominated by the American Society of Clinical Pathologists as a trustee of the American Board of Pathology and was voted into membership by this Board for a six-year term. Four trustees of the Board are nominated by the American Society of Clinical Pathologists, four by the Section of Physiology and Pathology of the American Medical Association and two others are chosen at large for six-year terms.

Dr. Stewart Thompson and Mr. Tom Jarvis of the headquarters staff attended the Southern Medical Association meeting in Miami November 10-13.

Dr. Walter W. Sackett, Jr., of Miami spoke on infant feeding at the recent scientific meeting of the Louisiana Academy of General Practice.

Dr. Walter C. Payne of Pensacola was elected second vice president of the Gulf Coast Clinical Society during the recent meeting of the Society in Pensacola. Dr. Alvin L. Stebbins of Pensacola retired as president and was succeeded by Dr. A. H. Zieman of Mobile, Ala.

The tenth anniversary of the Jacksonville Blood Bank was observed at a luncheon at the George Washington Hotel in October. A report of the Blood Bank's progress during the ten years was given, and the new medical director, Dr. John B. Ross, was introduced. Dr. Robert B. McIver, who has served the institution as president since its beginning, presided.

Dr. Alfred G. Levin of Miami has returned to his practice after taking a special advanced course in roentgenology of the gastrointestinal tract and heart at the University of Minnesota Medical School.

Dr. Curtis R. House of Fort Myers was a recent guest speaker at a meeting of District 7, Florida State Nurses' Association. His subject was "Cesarean Section, Indications for, Morbidity and Mortality."

Dr. Wilson T. Sowder of Jacksonville, director of the Florida State Board of Health, addressed the Woman's Auxiliary of the Dade County Medical Association recently. He spoke on the history of the state health department.

Dr. Gerald M. DeWoody of West Palm Beach was presented a plaque in recognition of his outstanding service to veterans by Edward J. Cooper, State Commander, Disabled American Veterans, at a meeting on November 12.

Dr. Floyd K. Hurt of Jacksonville spoke recently at the First Methodist Church of Macclenny on "Medicine and Religion."

Dr. James M. Nixon of Panama City was honored on his birthday, November 3, by his many friends for his years of service to that city and to Bay County. Dr. Nixon first started his practice there in 1913, and since that time he has delivered more than 5,000 babies.

Dr. Nathaniel M. Levin of Miami spoke on total laryngectomy and esophageal speech training technic in a panel discussion before the Institute on Voice Pathology, held at Western Reserve University, Cleveland, recently. He also served as a delegate to the First International Meeting of laryngectomized persons at the same time.

Dr. DeWitt C. Daughtry of Miami presented a paper on "Problems and Management of Lung Cysts" to the Southeastern Tuberculosis Conference on September 15.

Dr. Samuel F. Smith of Lakeland has returned to his practice after attending clinics at Temple University Hospital.

Members of the Florida Medical Advisory Committee for Selective Service met recently with state dentists' and physicians' committees in the Orange Court Hotel, Orlando, to discuss draft potential among Florida doctors, nurses, dentists and veterinarians. Dr. J. Rocher Chappell is chairman of the Association's Committee which includes: Drs. Thomas H. Bates, Lake City; Frank L. Fort, Jacksonville; Alvin L. Mills, St. Petersburg; and John D. Milton, Miami.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

WANTED: Capable, successful, Michigan G. P. desires opportunity in Palm Beach, Fort Lauderdale or Miami. Forty-two years, married, two children. Florida license. Will invest. Write 69-67, P. O. Box 1018, Jacksonville, Fla.

BELOW DEALERS COST: 6-piece Allison "Windsor" examination room set, beautiful walnut finish, used only 3 months. Also Birtcher diathermy Model 800, examination tables, sterilizers, and many other items at greatly reduced prices. Mark A. Gillespie, 1533 Santa Anna Dr., Dunedin, Fla., Phone 81-4353.

FOR SALE: 1-Four Bank (14" x 17" each) X-ray film illuminator, excellent condition. Sunseal Laboratories, Inc., Phone 286, Starke, Fla.

COMPONENT SOCIETY NOTES

Bay

Dr. Corbitt Thigpen, neuropsychiatrist from the Medical College of Georgia, Augusta, was guest speaker at the regular meeting of the Bay County Medical Society in October. He spoke on "depression" and stressed a "common-sense" approach to psychiatric problems.

Dade

At the regular monthly meeting of the Dade County Medical Association in November, Dr. James L. Anderson spoke on "The Importance of Hobbies in a Doctor's Life."

DeSoto-Hardee-Highlands-Glades

At the regular meeting of the DeSoto-Hardee-Highlands-Glades County Medical Society on October 14 at Aqua Vitae Springs, Zolfo, Dr. Harold G. Nix of Tampa spoke on "Ectopic Pregnancy."

Duval

At the regular monthly meeting of the Duval County Medical Society on November 4, Dr. Gould Andrews of the Atomic Research Center, Oak Ridge, Tenn., spoke on "The Use of Radioactive Isotopes in Medical Diseases." A motion picture on "Technic of Burns and Skin Graft," was also shown.

Through the efforts of the Society, "Your Doctor," A.M.A. sponsored documentary film being played in commercial threatres received wide publicity in Jacksonville. The Society's public relations committee worked with theatre officials to advise the public that the film had received the endorsement of the local medical society.

Marion

Dr. James D. Moody of Orlando was the guest speaker of the Marion County Medical Society at the regular monthly meeting on Oct. 21, 1952. His subject was "Common Diseases in Chest Surgery."

Announcing The Sixteenth Annual Meeting of

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters - Municipal Auditorium - March 2 - 5, 1953

GUEST SPEAKERS

J. Lamar Callaway, M.D., Durham, N. C.
Dermatology

A. H. Aaron, M.D., Buffalo, N. Y.
Gastroenterology

Herbert E. Schmitz, M.D., Chicago, Ill.
Gynecology

Carl V. Moore, M.D., St. Louis, Mo.
Hematology

Rudolph H. Kampmeier, M.D., Nashville, Tenn.
Internal Medicine

Henry A. Schroeder, M.D., St. Louis, Mo.
Internal Medicine

Guy L. Odom, M.D., Durham, N. C.
Neurosurgery

Andrew A. Marchetti, M.D., Washington, D. C.
Obstetrics

Harold F. Falls, M.D., Ann Arbor, Mich.
Ophthalmology

J. Vernon Luck, M.D., Los Angeles, Calif.
Orthopedic Surgery

G. Edward Tremble, M.D., Montreal, Can.
Otolaryngology

Arthur P. Stout, M.D., New York, N. Y.
Pathology

Waldo E. Nelson, M.D., Philadelphia, Pa.
Pediatrics

Edward B. D. Neuhauser, M.D., Boston, Mass.
Radiology

George Crile, Jr., M.D., Cleveland, Ohio
Surgery

Robert E. Gross, M.D., Boston, Mass.
Surgery

Charles W. Mayo, M.D., Rochester, Minn.
Surgery

Wyland F. Leadbetter, M.D., Boston, Mass.
Urology

LECTURES, SYMPOSIA, CLINICOPATHOLOGIC CONFERENCES, ROUND-TABLE LUNCHEONS, SURGICAL AND MEDICAL PROCEDURES IN COLOR TELEVISION, MEDICAL MOTION PICTURES AND TECHNICAL EXHIBITS.
(All-inclusive registration fee — $20.00)

THE POSTCLINICAL TOUR TO EUROPE BY SHIP AND PLANE — ENGLAND, FRANCE, SWITZERLAND AND ITALY — MARCH 7-31

For information concerning the Assembly meeting and the tour write Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

Ulcerations of Large Intestine due to Endamoeba *Histolytica*

Ulceration of the large or small intestine, perforation of the bowel, hepatitis and hepatic abscess are among the serious complications of intestinal infestation with Endamoeba histolytica.

"With the proper choice of drugs and with due consideration for the principles of therapy nearly all patients with amebiasis can be freed of infection rapidly and completely." The authors employ Diodoquin for treatment of gastrointestinal amebiasis.*

DIODOQUIN® (diiodohydroxyquinoline) — a potent amebacide developed by Searle Research — is orally administered, tasteless and well tolerated.

Tablets of 10 grains (650 mg.)
Bottles of 60 and 500.

*Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, J. Iowa M. Soc. 42:1 (Jan.) 1952.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Monroe

The Monroe County Medical Society has paid 100 per cent of its state dues for 1952.

Palm Beach

At the September meeting of the Palm Beach County Medical Society, Dr. James R. Anderson of West Palm Beach spoke on varicose veins.

At the regular monthly meeting of the Palm Beach County Medical Society in October, the guest speaker was Dr. Thomas J. E. O'Neill, pioneer in intracardiac surgery and associate professor of thoracic surgery at the Hahneman Hospital and Medical College, the Graduate School of the University of Pennsylvania and Temple University.

Pinellas

At the regular September meeting of the Pinellas County Medical Society, Dr. E. Ransom Koontz of St. Petersburg spoke on "Mediastinal and Pulmonary Tumors."

At the annual meeting of the Society in October, Dr. Everett M. Harrison of Clearwater was installed as president and presented the past president's plaque to the retiring president, Dr. John P. Rowell of St. Petersburg. Other officers elected to serve with Dr. Harrison for the current year are president-elect, Dr. Alvin L. Mills; first vice president, Dr. Clyde O. Anderson; and second vice president, Dr. Reid E. Dicks. Re-elected as secretary-treasurer was Dr. Whitman C. McConnell. All of these officers are from St. Petersburg.

Polk

Dr. A. Judson Graves of Jacksonville spoke at the October meeting of the Polk County Medical Society.

Volusia

All members of the Volusia County Medical Society have paid their state dues for 1952.

Dr. George P. Beach of Daytona Beach spoke on "Care of Fractures Not Requiring Hospitalization" at the October meeting of the Society.

Doctor, Journal Advertisers

Merit and Appreciate

Your Patronage

WOMAN'S AUXILIARY
TO THE
FLORIDA MEDICAL ASSOCIATION

OFFICERS

MRS. HERSCHEL G. COLE, President.....*Tampa*
MRS. THOMAS C. KENASTON, President-elect.....*Cocoa*
MRS. RICHARD F. STOVER, 1st Vice Pres.....*Miami*
MRS. NELSON A. MURRAY, 2nd Vice Pres.....*Jacksonville*
MRS. REAVES A. WILSON, 3rd Vice Pres.....*Sarasota*
MRS. TAYLOR W. GRIFFIN, 4th Vice Pres.....*Quincy*
MRS. ALBERT G. LOVE, IV, Recording Sec'y.....*Gainesville*
MRS. HERBERT B. LOTT, Correspd. Sec'y.....*Tampa*
MRS. SAMUEL S. LOMBARDO, Treasurer.....*Jacksonville*

COMMITTEE CHAIRMEN

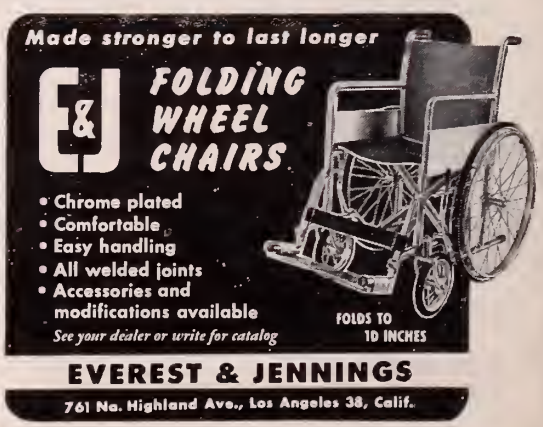
MRS. CHARLES F. HENLEY, Finance.....*Jacksonville*
MRS. EDWARD F. SHAVER, Today's Health.....*Tampa*
MRS. ALVIN L. MILLS, Legislation.....*St. Petersburg*
MRS. C. RUSSELL MORGAN, JR., Public Relations....*Miami*
MRS. WILLIAM G. MERIWETHER, Reference.....*Plant City*
MRS. SHERREL D. PATTON, Civil Defense.....*Sarasota*
MRS. CARROLL V. HERRON, Projects.....*Daytona Beach*
MRS. JULIUS ALEXANDER, Program.....*Miami*
MRS. JAMES T. COOK, JR., Bulletin.....*Marianna*
MRS. GEORGE H. PUTNAM, Historian.....*Gainesville*
MRS. ANGUS D. GRACE, Parliamentarian.....*Fort Myers*
MRS. ALFONSO F. MASSARO, Revisions.....*Tampa*
MRS. JOHN E. MAINES, JR., Stu. Loan Fund....*Gainesville*
MRS. ARTHUR R. KNAUF, Medaux.....*Tampa*
MRS. CHARLES McD. HARRIS, JR., Study Group.....*W. P. Beach*
MRS. C. ROBERT DEARMAS, Auxiliary Writer for State Medical Journal.....*Daytona Beach*
MRS. EDWARD W. CULLIPHER, Stu. Nurse Recruit. *Miami*
MRS. LEFFIE M. CARLTON, JR., Hospitality.....*Tampa*

The Workshop Plan

The workshop plan went into its second year on the Medical District Meeting tour and we can say with few exceptions that it grows in importance rather than diminishes.

The title, "workshop," is a misnomer and implies tedium, which is unfortunate, because the activity is in fact a mere exchange of constructive ideas among intelligent women who are interested in the same thing, who are by this opportunity able to clarify points and stimulate thought in auxiliary matters.

This function of the auxiliary officers is valuable. A few minutes can be given in each district to explain the aims, objectives and methods of the organization to a cross section of doctors' wives.



Some of these wives are not even members of the auxiliary because they fail to understand what is accomplished by this group.

It is not wasted effort since auxiliary information is frequently acquired at various times in different and indifferent degrees. Since a person's membership is voluntary, and she becomes eligible solely by virtue of her husband's membership in the county society, there is a noticeable lack of application to the mechanics of the organization on a large scale.

If a waiting or probationary period could be instituted requiring full knowledge of the Association's charter and by-laws before one is accepted as a full fledged member, the awareness of the group would suddenly develop a force and power more beneficial to the men it serves. Until that time, we must content ourselves with "workshop" methods to instruct and guide.

The Association officers who took their time and attended the Medical District Meetings in October can be congratulated upon the splendid interpretation they gave. In so doing they achieved a better unity between state and county wherever they spoke.

Mrs. C. Robert DeArmas

Cook County Graduate School of Medicine

POSTGRADUATE COURSES — WINTER 1952-53

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting January 19, February 2, February 16. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 2. Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 16. Basic Principles in General Surgery, Two Weeks, starting March 23. Gallbladder Surgery, Ten Hours, starting April 20. Surgery of Colon & Rectum, One Week, starting March 2. General Surgery, One Week, starting February 9. General Surgery, Two Weeks, starting April 20. Fractures and Traumatic Surgery, Two Weeks, starting March 2.

GYNECOLOGY—Intensive Course, Two Weeks, starting February 16. Vaginal Approach to Pelvic Surgery, One Week, starting March 2.

OBSTETRICS—Intensive Course, Two Weeks, starting March 2.

PEDIATRICS—Intensive Course, Two Weeks, starting April 6.

MEDICINE—Intensive General Course, Two Weeks, starting May 4. Electrocardiography & Heart Disease, Two Weeks, starting March 16. Allergy, One Month and Six Months, by appointment.

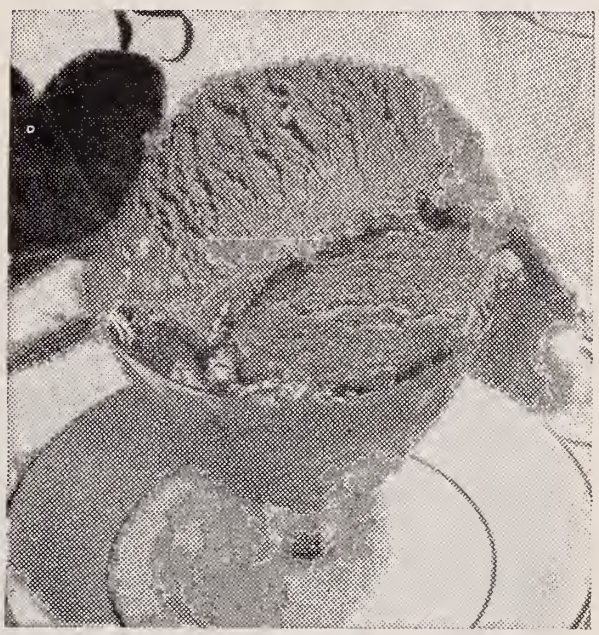
UROLOGY—Intensive Course, Two Weeks, starting April 13. Ten-Day Practical Course in Cystoscopy starting every two weeks.

DERMATOLOGY—Intensive Course, Two Weeks, starting May 4.

Teaching Faculty:
Attending Staff of Cook County Hospital
Address: Registrar, 707 South Wood Street
Chicago 12, Illinois

Rx

...FOR BOTH DOCTOR AND PATIENT



• The name Sealtest is your guarantee of rich, wholesome dairy foods—healthful refreshment at its nourishing best.

Southern Dairies
Sealtest
ICE CREAM

OBITUARIES

George Clarence Tillman

Dr. George Clarence Tillman of Clearwater died at the Morton Plant Hospital in that city of a heart ailment on June 29, 1952. He became seriously ill two months previously at Vero Beach while returning from the annual meeting of the Florida Medical Association at Hollywood and was hospitalized at the Indian River Memorial Hospital in Vero Beach for several weeks before being moved to the Morton Plant Hospital in Clearwater. He was 61 years of age. Interment took place at Crosby Lake Cemetery, near Starke.

Dr. Tillman was born at Baxley, Ga., on Oct. 7, 1890. A graduate of Georgia Institute of Technology, he also received his medical education in his native state, being awarded the degree of Doctor of Medicine by Emory University School of Medicine in 1914. For the next two years he was resident physician at St. Luke's Hospital in Jacksonville and later did graduate work at the Johns Hopkins University School of Medicine.

During World War I, he served in the Medical Corps of the United States Army. He was discharged with the rank of captain.

After the war Dr. Tillman located in Gainesville and engaged in the general practice of medicine. For many years he was chief medical officer of the University of Florida. While residing in Gainesville, he was a member of the Alachua County Medical Society and of the surgical staff of the Alachua General Hospital. For the last seven years he had made his home in Clearwater, where he specialized in gynecology and obstetrics and was a member of the staff of the Morton Plant Hospital. He was a member of the Phi Chi and Alpha Epsilon Delta fraternities and of the Knights Templar.

Dr. Tillman was a member of the Pinellas County Medical Society; for 35 years a member of the Florida Medical Association, and also a member of the American Medical Association. He held a life membership in the American College of

ONE OF AMERICA'S FINEST INSTITUTIONS . . .

BROOK HAVEN MANOR...

with a well trained staff of nurses and attendants, fills the need for a high class, ethical nursing home.

Convalescents and elderly patients receive individual attention in these lovely surroundings.

Alcoholics, drug addicts and mental patients are not accepted.

Physicians are invited to continue supervision of their patients.

Rates moderate, based on individual needs.

Dedicated to the Welfare of the Convalescent and Elderly

BROOK HAVEN MANOR SANITARIUM

STONE MOUNTAIN, GA.

ATTENDING PHYSICIANS:
DR. J. RUFUS EVANS
DR. WILLIS MCCURDY

NURSES:
MISS ELIZABETH C. HANCOCK
MRS. CARRO HENDERSON
MRS. CUMEI ANDREI, *Chief Dietician*

Surgeons and was a member of the Southeastern Surgical Congress.

Surviving are the widow, Mrs. Ardith Manss Tillman of Clearwater; a son, George Bernon Tillman of Lake Wales; a daughter, Mrs. Clara Anne Stanton of Orlando; three grandchildren; two brothers, Raleigh Tillman and Walter Tillman, both of Lake Wales; his stepmother, Mrs. Effie Tillman of Lake Wales; three half brothers, Gilbert Bernon Tillman of Lakeland, and Spurgeon Tillman and Campbell Tillman, both of Dade City; and a half sister, Mrs. William R. Gooch of Lake Wales.

Joseph Enoch Taylor

Dr. Joseph Enoch Taylor of DeLand died at his home on July 10, 1952 of a heart ailment following several weeks' illness. He was 65 years of age.

The son of John E. D. Taylor and Virginia Avery Taylor, Dr. Taylor was born in Carrollton, Ga., on Aug. 23, 1886. Educated in his native state, he received his early schooling and premedical training at Walker Institute in Newnan. He was graduated from the University of Georgia School of Medicine in 1913. He then interned at Children's Hospital in Augusta. Thereafter, he came to Florida as Assistant State Healtl. Officer and was in charge of children's diseases for the State Board of Health for eight years.

From 1921 until the time of his death Dr. Taylor engaged in the private practice of internal medicine in DeLand. He remained active in State Board of Health matters, however, and was instrumental in establishing the Volusia County Health Unit. For a short period of time he served as State Health Officer. He was serving as chief of staff of DeLand Memorial Hospital at the time of his death and had been City Health Officer and County Physician. He was a member of the Athenian Club and the DeLand Chamber of Commerce. Long a member of St. Barnabas Episcopal Church, he had served as vestryman and senior warden, and at the time of his death was honorary senior warden. A citrus grower, he was interested in many phases of the fruit business.

Dr. Taylor was a member and a past president of the Volusia County Medical Society. He was for 39 years a member of the Florida Medical

BALLAST POINT MANOR

Care of Mild Mental Cases, Senile Disorders
and Invalids
Alcoholics Treated

Aged adjudged cases will be accepted on either permanent or temporary basis.

ACCREDITED HOSPITAL FOR NEUROLOGICAL PATIENTS by
American Medical Assn.
American Hospital Assn.
Florida Hospital Assn.

5226 Nichol St.
Telephone 62-2332

DON SAVAGE
Owner and Manager

P. O. Box 10368
Tampa 9, Florida

Association and for four years had been a life member. He was also a member of the American Medical Association.

On July 7, 1913 Dr. Taylor was married in Montgomery, Ala., to Margaret Virginia McGough, who survives him. Also surviving are one daughter, Mrs. Margaret Virginia Peek, two grandsons, Joseph Taylor Peek and Leon Ashley Peek, and one granddaughter, Margaret Cecelia Peek, all of DeLand.

William Duncan Owens

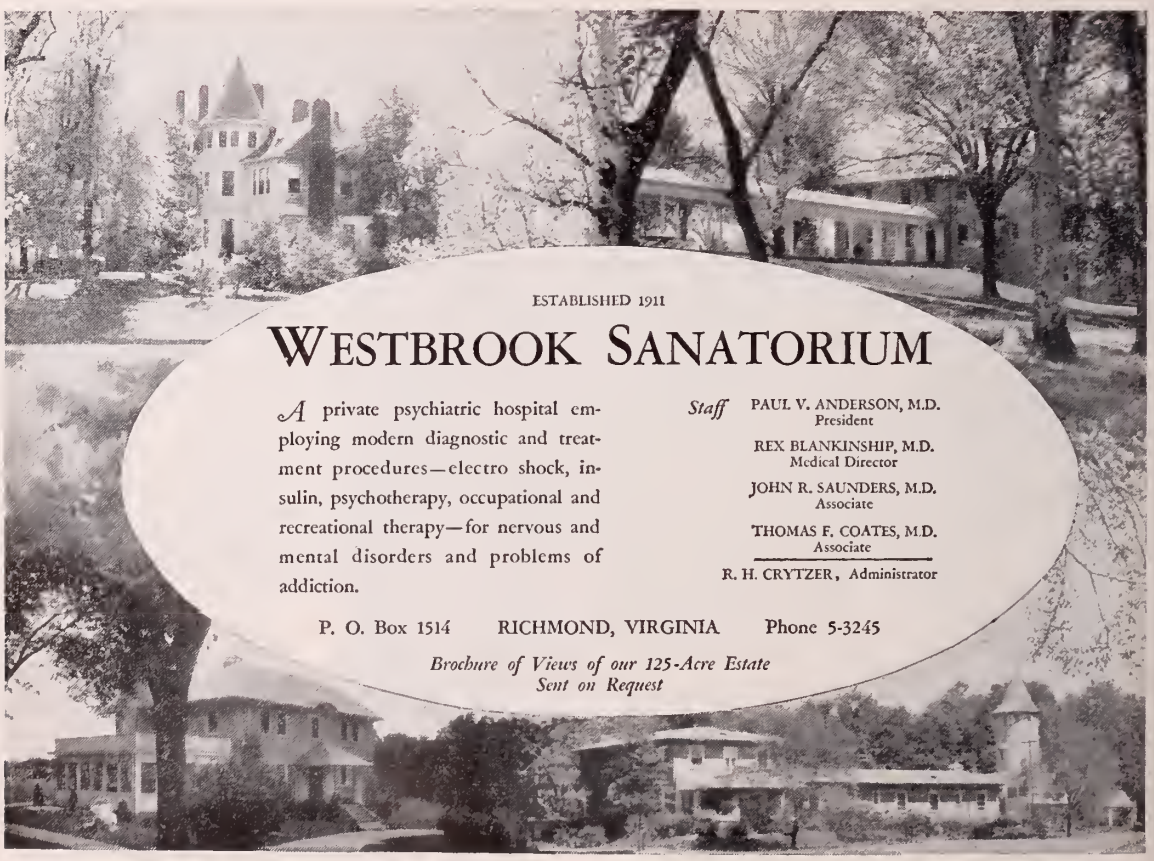
Dr. William Duncan Owens, formerly of Miami, met sudden death from coronary occlusion on Aug. 6, 1952 at his home in Warrenton, Va., while pruning a tree in his orchard. He was 58 years of age. Interment took place in Savannah, Ga.

A native of Georgia, Dr. Owens was born in Savannah on June 22, 1894. He attended Woodberry Forest School, the University of Georgia and the University of Virginia. In 1919 he received the degree of Doctor of Medicine from the University of Maryland School of Medicine and College of Physicians and Surgeons. After completing an internship at Baltimore City Hospital, he was resident surgeon at University Hospital in Baltimore and then house surgeon at the Woman's Hospital in New York. Among his various postgraduate studies, the most recent course was in Neurosurgery at the University of Michigan.

Dr. Owens began the practice of medicine in Miami in 1932. His specialty was surgery. He was an active member of the staff of Jackson Memorial Hospital and was Senior Attending Surgeon there when he retired. He was also a member of the staff of St. Francis' Hospital. He held membership in the Rotary, Bath and Indian Creek clubs.

After serving four years as a commander in the United States Navy during World War II, Dr. Owens returned to Miami in 1946, but did not regain his failing health. In 1948 he retired to his Virginia farm.

Dr. Owens was a member of the Dade County Medical Association. He was also a member of the Florida Medical Association and on its Board of Governors at the time of his retirement. In addition, he was affiliated with the American



Medical Association, and throughout the years of his residence in Florida was active in organized medicine.

On April 9, 1924, Dr. Owens was married to Wilmotine Perdue of Atlanta, Ga., who survives him. Other survivors are three daughters in Virginia and three grandchildren.

Samuel Foster Ricker

Dr. Samuel Foster Ricker of Orlando died in the Orange Memorial Hospital on Aug. 18, 1952 from coronary heart disease. He was 52 years of age.

Dr. Ricker was born in Emporia, Kan., on April 1, 1900. He was educated in the schools of Emporia and received his medical degree from the University of Kansas School of Medicine in 1925. Following an internship in Des Moines, Iowa, he began the general practice of medicine in St. Charles, Iowa, going to Des Moines two years later. Four years thereafter, because of a cardiac condition, he took a postgraduate course in dermatology at the New York Skin and Cancer Clinic. Upon completion of this course, he came to Florida in 1935, opening his office in Orlando and limiting his practice to dermatology.

He was an attending physician at the Orange Memorial Hospital and a consultant of the Orange County branch of the Central Florida Tuberculosis Hospital. His medical fraternity was Phi Chi. Locally, he was a member of the Exchange Club, the Executive Club, the Current Club, the Greater Orlando Chamber of Commerce and the First Methodist Church. He held membership in the Masonic Home Lodge No. 370 of Des Moines.

A member of the Orange County Medical Society, Dr. Ricker was also a member of the Florida Medical Association, the Southern Medical Association and the American Medical Association. He was a member of the Florida Dermatological Society, of which he was a past president, and of the Southeastern Dermatological Association.

Surviving are the widow, Mrs. Mary Jane Ricker; one son, Carl J. Ricker of Orlando; one daughter, Mrs. Hamilton C. Jones, Jr., also of Orlando; one granddaughter, Helen Elizabeth Ricker; and one sister, Mrs. Ruth Ricker Macurdy of Emporia, Kan.

Advertisement

From where I sit
by Joe Marsh

Left Ham Sandwich, 40¢

Ambled over to Bob's Restaurant Tuesday for lunch and noticed a new sign "Left Ham Sandwich, 40¢ . . . Right Ham Sandwich, 30¢."

"Why the sign, Bob?" I asked. "Don't tell me you believe hogs scratch more with their right leg than with their left—so that the left ham is more tender?"

"No," he says. "I don't take any stock in it. But, some people *have* ordered those 'left' sandwiches. When I explain to them that there's nothing to that fable, that the sign is just a business-getter, and I've only *one* price, they enjoy a regular, old-fashioned, plain ham sandwich all the more!"

From where I sit, stories like "right" hams being tougher than "left" ones are with us because some people get ideas and hang onto them for dear life. It's like those people who would interfere with a man practicing his profession or those who would deny me a glass of beer. I say let's keep our opinions free from being "sandwiched-in" by misinformation.

Joe Marsh

Copyright, 1952, United States Brewers Foundation

BOOKS RECEIVED

Bacitracin. A Review and Digest of the Literature Up to and Including January, 1952. Pp. 127. New York, Research Division, S. B. Penick & Company, 1952.

The purpose of this book is to discuss the status of bacitracin in the armamentarium of the general practitioner as well as the specialist. In its pages has been collected and organized all the literature to date on bacitracin usage throughout the world. Attention is directed to the wide potential of this drug based upon its known synergistic action with other antibiotics.

The ten chapters deal with history, chemistry, assay, pharmacology, bacteriologic aspects, clinical results, efficacy in veterinary medicine, synergistic action, dosage and formulations, and summary. Declaring that "within its antibacterial spectrum, bacitracin approaches the ideal more nearly than any other antibiotic," the authors invite particular attention to the last chapter, entitled "Summary. Bacitracin on the Antibiotic Horizon," which gives a resume of the properties of the drug.

New and Nonofficial Remedies, 1952. Issued Under the Direction and Supervision of The Council on Pharmacy and Chemistry, American Medical Association. Pp. 838. Price, $3.00. Philadelphia, J. B. Lippincott Company, 1952.

Included in this annual publication are articles which the Council on Pharmacy and Chemistry of the American Medical Association has found acceptable under its rules through the period ending January 1 of the year of publication. Essentially, the book consists of two major divisions: Section A with general statements on broad classifications of preparations, and monographs describing the actions, usage, and dosage of specific articles; and Section B with physical descriptions, tests, and standards for Council accepted drugs for which official standards are not available.

In order to keep pace with changes in therapeutics, the Council annually reviews and revises the general statements and monographs and eliminates those articles no longer considered useful. The 1952 volume provides the physician with such information concerning the actions, usage, limitations, and dosage of acceptable and relatively new drugs as will promote the practice of rational therapeutics.

Dynamic Psychiatry. Transvestism — Desire for Crippled Women. By Louis S. London, M.D. Vol. 2. Pp. 129. Price, $2.50. New York, Corinthian Publications, Inc., 1952.

Defining transvestism as a form of sexual deviation in which the person desires to play the role of the opposite sex by crossed dressing, the author describes a case which he believes to be unique in psychiatric literature. The patient had a psychopathologic interest in crippled women, dwarfs, freaks and cross-eyed, bearded women, and he sometimes masqueraded as either a male or female cripple.

The first chapter is devoted to an anthropologic and historical account of transvestism. Fifty psychobiographic fantasies drawn by the patient, described in his own language and reproduced at his request comprise the second chapter. In the third and concluding chapter, Dr. London presents his analysis of the case.

Volume 1 of Dynamic Psychiatry was reviewed in the July Journal.

BISCAYNE HOSPITAL
6339 Biscayne Blvd.
MIAMI 38, FLORIDA

Members of the Dade County Medical Association are acquainted with the high type of service rendered.

David Collins, Superintendent

Registered, American Medical Association
Phone 7-4544

MIAMI RETREAT SANATORIUM
FOUNDED 1927
For Nervous and Mental Disorders, Alcohol and Drug Addiction

STAFF OF EIGHT NEUROPSYCHIATRISTS
New X-Ray Diagnostic Treatment Facilities
Comfortable AIR-CONDITIONED rooms, suites

79TH STREET AT MIAMI AVENUE
MIAMI 38, FLORIDA
Phone 7-1824

FOR SAFETY AND ACCURACY IN UROGRAPHY

Clinical experience in thousands of cases has demonstrated the notable safety of urinary tract visualization with NEO-IOPAX® (Sodium Iodomethamate U.S.P.).

NEO-IOPAX

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

The urograms obtained have always been noteworthy for their clear delineation of the kidneys, ureters, and bladder.

Schering CORPORATION
BLOOMFIELD, NEW JERSEY

NEO-IOPAX

SCHERING

DOCTOR . . . now YOU can buy OSMOSE TREATED FENCE POSTS . . . at our CARLOAD PRICE

OSMOSE TREATED FENCE POSTS
— Last 3 to 5 times longer — Resist termites!

Doctors were among the first to appreciate the tremendous savings in time, labor and materials that were made possible by the use of Osmose Treated Fence Posts. Doctors everywhere have also been big boosters for these tougher, longer lasting posts! Because of this, we are making this offer in State Medical Journals throughout the South.

As you may know, Osmose Treated Fence Posts are scientifically treated to make the cellulose fibers in the wood unpalatable to the tiny micro-organisms that normally feed on them. With their food supply cut off, these fungi either die or look elsewhere for sustenance.

Osmose Treated Fence Posts last up to five times longer, resist the attack of all wood destroying insects and are fire retardant.

If you have a fairly large place, you can easily use 2000 fence posts, which is approximately the number of posts contained in a standard car. If not, perhaps one of your neighbors would welcome the opportunity to share the surplus. Write us today for complete prices and data.

SOUTHERN SALES OFFICES
R. D. DIXON
BOX 298
GRIFFIN, GA.

OSMOSE WOOD PRESERVING CO. Offices and Mills throughout the South

RELAXED . . . *but awake*

In the many cases which require sedation without excessive hypnosis, Mebaral is of outstanding merit.

With its relatively wide margin between sedative and hypnotic dosage, Mebaral may be employed in those conditions in which relief from anxiety, depression or agitation is desired during the waking hours.

INDICATIONS:

Mebaral affords alleviation of tension in the hyperthyroid or hypertensive patient, relaxation in neuroses and mild psychoses, a calming influence in the high-strung menopausal patient. It is also a reliable anticonvulsant in epilepsy.

Mebaral®

TASTELESS TABLETS

Tablets of 32 mg. (½ grain), 0.1 Gm. (1½ grains) and 0.2 Gm. (3 grains)

WINTHROP-STEARNS INC., New York 18, N.Y., Windsor, Ont.

Mebaral, trademark reg. U. S. & Canada, brand of mephobarbital

The Right to *Choose* . . . .

CORNERSTONE OF AMERICAN LIBERTY

Hospital Expense Plans

Medical-Surgical Expense Plans

Paycheck Protection Plans

Life Insurance Plan

AS long as Americans keep the right to choose — their church, their political party, their doctor and their hospital — freedom must prevail.

We are proud that hundreds of thousands of Americans have freely chosen the protection afforded them by PENNSYLVANIA LIFE'S liberal, low-cost health insurance plan.

Pennsylvania Life
HEALTH & ACCIDENT **Insurance Company**

FOUNDED 1890

HOME OFFICE: PHILADELPHIA 5, PA.

19 District Offices in Florida

Miami	Executive Office 3028 Biscayne Blvd.	Fort Lauderdale	521½ South Andrew Avenue
	Downtown 1210 Pacific Building	Jacksonville	303 Clark Building
	Southwest 1260 S. W. 22nd Street	Tampa	228 Cass Street Arcade Building
	Little River 8340 N.E. Second Ave., Suite 245	Sarasota	237 Main Street, Room 15
	Coral Gables 3028 Biscayne Blvd.	Fort Pierce	Florida Bank Building, Room 34
	Miami Beach 206 Harvey Building	Daytona Beach	116½ Orange Avenue
St. Petersburg	509 White Building	Tallahassee	429 Centennial Building
Lakeland	206 Marble Arcade	Panama City	142 Harrison Avenue
West Palm Beach	305 Citizens Building	Pensacola	501 Theisen Building
Orlando	209 Slayton Building		

CAMELS

mild and
flavorful!

pack after
pack!

Allen's Invalid Home

MILLEDGEVILLE, GA.

Established 1890
For the treatment of
NERVOUS AND MENTAL DISEASES

Grounds 600 Acres
Buildings Brick Fireproof
Comfortable Convenient
Site High and Healthful

E. W. ALLEN, M.D., *Department for Men*
H. D. ALLEN, M.D., *Department for Women*
Terms Reasonable

THE EARLE JOHNSON SANATORIUM

For the care of nervous, mental, senile, alcoholic, and addicted cases. **Moderate rates.**

Operated by C. Earle Johnson, Jr., M.D., Psychiatrist-in-Chief, F.A.P.A., F.A.C.P. Diplomate of the American Board of Psychiatry and Neurology.

The most modern and effective psychiatric methods are employed. Gradual reduction in the addictions; Antabuse treatment for alcoholism.

Telephone: 3-3369 or 3-3360
Write: Drawer 106
Meridian, Mississippi

Janet's Nursery for Babies

P. O. Box 191
OSPREY, FLORIDA
Phone RIngling 4-1647

A Nursery for Handicapped Babies

For Information write
H. KEITH JACOBUS
P. O. Box 191
Osprey, Florida

S. A. Kyle — *Funeral Director*

MEMBER National Selected Morticians BY INVITATION

17 WEST UNION STREET
JACKSONVILLE 2, FLORIDA
Phones 5-3766 5-3767

MIAMI MEDICAL CENTER

P. L. DODGE, M.D.
Medical Director and President

1861 N. W. South River Drive
Phones 2-0243 — 9-1448

A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures — Psychotherapy, Insulin, Electroshock, Hydrotherapy, Diathermy and Physiotherapy when indicated. Adequate facilities for recreation and out-door activities. Cruising and fishing trips on hospital yacht.

Information on request
Member American Hospital Association

HILL CREST SANITARIUM

FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

Thoroughly modern in architecture and construction. Eight departments — affording proper classification of patients. All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

James A. Becton, M.D., Physician-in-charge — James Keene Ward, M.D., Associate Physician

P. O. Box 2896, Woodlawn Station, Birmingham, Alabama — **Phones 9-1151 and 9-1152**

TUCKER HOSPITAL, INC.

212 West Franklin Street

Richmond, Virginia

A private hospital accepting for diagnosis and treatment organic neurological conditions, selected psychiatric and alcoholic cases, metabolic disturbances of an endocrine nature, individuals who are having difficulty with their personality adjustments, and children with behavior problems. Patients with general medical disorders admitted for treatment under our staff of visiting physicians.

Under the Professional Charge of

Dr. Howard R. Masters,
Dr. James Asa Shield and Associates

HIGHLAND HOSPITAL, INC.

FOUNDED IN 1904

Asheville, North Carolina

AFFILIATED WITH DUKE UNIVERSITY

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a sixty-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D.,
Diplomate in Psychiatry
Medical Director

ROBT. L. CRAIG, M.D.,
Diplomate in Neurology and Psychiatry
Associate Director

CONVENTION PRESS

218 WEST CHURCH STREET
JACKSONVILLE
FLORIDA

Commercial and
Publication
Printing

BRAWNER'S SANITARIUM

Established 1910

SMYRNA, GEORGIA
(Suburb of Atlanta)

For Nervous and Mental Disorders
Drug and Alcohol Addiction
Electro-Shock in selected cases

JAMES N. BRAWNER, M.D., Medical Director
ALBERT F. BRAWNER, M.D., Department for Men
JAMES N. BRAWNER, JR., M.D., Department for Women

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Medical Association	Robert B. McIver, Jacksonville	Samuel M. Day, Jacksonville	Hollywood, Apr. 26-29, '53
Medical Districts	Eugene G. Peck, Jr., Ocala	Council Chairman	
thwest	Francis M. Watson, Marianna	Benjamin A. Wilkinson, Tallahassee	Tallahassee, 1953
theast	William C. Thomas, Jr., Gainesville	Eugene L. Jewett, Orlando	St. Augustine, 1953
nwest	Emmett E. Martin, Haines City	Hugh G. Reaves, Sarasota	Tampa, 1953
theast	Erasmus B. Hardee, Vero Beach	Donald W. Smith, Miami	West Palm Beach, 1953
pecialty Societies			
of General Practice	Edward F. Shaver, Tampa	Frank T. Linz, Tampa	Hollywood, Apr. 26, '53
ciety	Nelson Zivitz, Miami Beach	Solomon D. Klotz, Orlando	" "
ologists, Soc. of	John T. Stage, Jacksonville	Breckenridge W. Wing, Orlando	" "
Am. Coll. Chest Phys.	Alexander Libow, Miami Beach	DeWitt C. Daughtry, Miami	" "
l Syph., Soc. of	Lewis Capland, Miami Beach	Morris Waisman, Tampa	" "
ficers' Society	George W. Edwards, II, Orlando	Lorenzo L. Parks, Jacksonville	" "
& Railway Surgeons	John H. Mitchell, Jacksonville	William H. Chapman, Jacksonville	" "
& Psychiatry	W. Tracy Haverfield, Miami	Roger E. Phillips, Orlando	" "
Gynec. Society	Dorothy D. Brame, Orlando	J. Champneys Taylor, Jacksonville	" "
Otol., Soc. of	Joseph W. Taylor, Sr., Tampa	Carl S. McLemore, Orlando	" "
c Society	Arthur H. Weiland, Coral Gables	Edward W. Cullipher, Miami	" "
ts, Society of	Robert J. Poppiti, Miami Beach	Alfred E. Cronkite, Fort Lauderdale	" "
Society	Charlotte C. Maguire, Orlando	Wesley S. Nock, Coral Gables	" "
c Society	Alex. E. Rosenberg, Miami Bch.	George Williams, Jr., Miami	" "
al Society	Thomas H. Lipscomb, Jacksonville	A. Judson Graves, Jacksonville	" "
Society	George H. Putnam, Gainesville	David W. Goddard, Daytona Beach	" "
cience Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 6, '53
Banks, Association	Donald W. Smith, Miami	Mr. J. M. Potts, Miami	Miami, May, 1953
oss of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
ield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Mother Loretto Mary, Tampa	Hollywood, Apr. 26, '53
Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Jacksonville, Dec. 7, '52
Society, State	W. G. McLeod, D.D.S., Pensacola	Coleman Brown, D.D.S., Tampa	St. Petersburg, Apr. 20-23, '53
Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
l Association	Mr. T. F. Little, Daytona Beach	Mr. Tracy B. Hare, Miami	
l Examining Board	Ralph B. Spires, DeFuniak Springs	Homer L. Pearson, Jr., Miami	
l Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
s Association, State	Miss Undine Sams, Miami	Bertha King, Tampa	
ceutical Association, State	Mr. Clyde Morris, Daytona Beach	Mr. R. Q. Richards, Ft. Myers	St. Petersburg, May, '53
l Health Association	Mr. Angus Laird, Tallahassee	Mr. Fred B. Ragland, Jacksonville	Tampa, 1953
culosis & Health Assn.	Leffie M. Carlton, Jr., Tampa	Mrs. L. C. Conant, Fort Myers	Jacksonville, May 14-15, '53
n's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	Hollywood, Apr. 26-28, '53
c Medical Association	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	New York, June 1-5, '53
l Clinical Session	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	Denver, Dec. 2-5, '52
e Medical Association	Walter C. Jones, Miami	Mr. C. P. Loranz, Birmingham	Atlanta, 1953
n Medical Association	B. W. McNease, Fayette	Douglas L. Cannon, Montgomery	Birmingham, Apr. 16-18, '53
n Medical Assn. of	C. F. Holton, Savannah	Mr. Sid Wrightsman, Atlanta	Savannah, May 10-13, '53
pital Conference	Mr. Norman Losh, Orlando	Mr. D. O. McClusky, Tuscal'sa, Ala.	New Orleans, April 8-10, '53
ern Allergy Assn.	Clarence Thomas, Nashville, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Havana, Cuba, Mar. 26-29, '53
ern, Am. Urological Assn.	William Miner, Covington, Ky.	Sidney Smith, Raleigh, N. C.	Nashville, May, '53
ern Surgical Congress	H. L. Claud, Washington, D. C.	B. T. Beasley, Atlanta	Louisville, Mar. 9-12, '53
st Clinical Society	Hays Zieman, Mobile, Ala.	William Atkinson, Mobile, Ala.	Mobile, Oct., '53

•In MIAMI SANITARIUM

Medical Hospital American Plan Hotel for Patients and their families. REST, CONVALESCENCE, ACUTE and CHRONIC MEDICAL CASES. Elderly People and Invalids. ***FREE Booklet!***

Acres Tropical Grounds, Delicious Meals, Res. Physician, Grad. Nurses, Dietitian.

SUN-RAY PARK HEALTH RESORT

Mild Mental Cases, Drug and Alcoholics in Separate Building

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS Total	MEMBERS Paid	COUNCILO
A	Bay	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	William F. Humphreys, Jr., M.D. 112 E. 3rd Court Panama City	1st Tuesday 7:30 P.M.	24	100%	
	Escambia *Santa Rosa*	Chas. J. Heinberg, M.D. 109 N. Baylen St. Pensacola	Raymond B. Squires, M.D. 386 Brent Bldg. Pensacola	2nd Tuesday 8:00 P.M.	76	100%	
	Franklin-Gulf	John W. Hendrix, M.D. Port St. Joe	Photis J. Nichols, M.D. Apalachicola	Last Wednesday	7	100%	A-1-54 Francis M. Watson, M.I Marianna
	Jackson-Calhoun	Albert E. McQuagge, M.D. 207 N. Green St. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	16	
	Walton-Okaloosa	William D. Cawthon, M.D. DeFuniak Springs	Edgar H. Myers, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	100%	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		5	100%	
	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	100%	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	Ernest W. Ekermeyer, M.D. 516 N. Adams St. Tallahassee	George H. Massey, M.D. 204 N. Madison St. Quincy	Quarterly 7:30 P.M.	61	58	
	Suwannee	Edward G. Haskell, Jr., M.D. Branford	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak	1st Saturday 9:30 A.M.	8	100%	A-2-53 Benjamin A Wilkinson, M. Tallahassee
	Madison	A. Franklin Harrison, M.D. Madison	Eugene D. Thorpe, M.D. Madison		3	100%	
	Taylor *Dixie, Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	3	100%	234
B	Alachua *Bradford, Gilchrist, Union*	Henry J. Babers, Jr., M.D. Box 709 Gainesville	Raymond S. Camp, M.D. 907 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	48	47	
	Duval *Clay*	Ferdinand Richards, M.D. 508 Greenleaf Bldg. Jacksonville	Joseph A. J. Farrington, M.D. 415 Greenleaf Bldg. Jacksonville	1st Tuesday 8:15 P.M.	255	247	
	Marion *Levy*	Carl S. Lytle, M.D. 1206 E. Ocklawaha Ave. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	29	27	B-3-54 William C. Thomas, Jr., M Gainesville
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	11	100%	
	Putnam	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	Bennie J. Massey, M.D. Box 105 Palatka	2nd Tuesday 6:00 P.M.	10	9	
	St. Johns	Charles C. Grace, M.D. 145 King St. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
	Brevard	James A. Sewell, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	23	22	
	Lake *Sumter*	Robert H. Montgomery, M.D. Mount Dora	J. Basil Hall, M.D. Mount Dora	1st Wednesday 7:30 P.M.	26	100%	B-4-53 Eugene L. Jewett, D. Orlando
	Orange *Osceola*	Carl S. McLemore, M.D. 1217 Kuhl Ave. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	155	152	
	Seminole	Julian N. Tolar, M.D. First Street Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	16	100%	
	Volusia *Flagler*	J. Richard West, M.D. 224 S. Palmetto Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	78	100%	666
C	Hillsborough	Sherman B. Forbes, M.D. 409 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	176	173	
	Manatee	John E. Granade, M.D. 114 Walcaid Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	18	17	
	Pasco-Hernando- Citrus	William H. Walters, Jr., M.D. Lacoochee	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	16	100%	C-5-53 Hugh G. Reaves, D. Sarasota
	Pinellas	Everett M. Harrison, M.D. 1601 N. Fort Harrison Ave. Clearwater	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Mon. Even Mo. 1st Fri. Odd Mo. 6:00 P.M.	193	100%	
	Sarasota	Henry G. Morton, M.D. 555 Golf St. Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	2nd Tuesday 8:30 P.M.	44	100%	
	DeSoto-Hardee- Highlands- Glades	Harold S. Agnew, M.D. 705 E. Oak St. Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	26	24	
	Lee-Charlotte- Collier-Hendry	John S. Stewart, M.D. Lee Memorial Hosp. Fort Myers	Harvie J. Stipe, M.D. 210 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	24	23	C-6-54 Emmett E. Martin, M.D Haines City
	Polk	Ivan W. Gessler, M.D. 402 Professional Bldg. Winter Haven	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	92	89	589
D	Indian River	P. T. McClellan, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	6	
	Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Drive West Palm Beach	David A. Newman, M.D. 511 Citizens Bldg. West Palm Beach	3rd Monday 8:00 P.M.	119	100%	D-7-54 Erasmus B. Hardee, M.D Vero Beach
	St. Lucie- Okeechobee- Martin	Richard F. Sinnott, M.D. 209 Koblegard Bldg. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	16	14	
	Broward	Lloyd U. Lumpkin, M.D. 918 E. Las Olas Blvd. Ft. Lauderdale	William K. Peck, M.D. 915 N. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	84	83	
	Dade	Ralph S. Sappenfield, M.D. 630 duPont Bldg. Miami	Nelson Zivitz, M.D. 311 Lincoln Rd. Miami Beach	1st Tuesday 8:30 P.M.	618	593	D-8-53 Donald W. Smith, D Miami
	Monroe	James B. Parramore, M.D. Box 326 Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	15	100%	859

*Supervise and aid until organized separately.

Total 2,348

The Birth of Jesus Christ as told in the second chapter of the gospel according to Saint Luke:

And it came to pass in those days, that there went out a decree from Cæsar Augustus, that all the world should be taxed. (And this taxing was first made when Cyrenius was governor of Syria.) And all went to be taxed, every one into his own city. And Joseph also went up from Galilee, out of the city of Nazareth, into Judæa, unto the city of David, which is called Bethlehem; (because he was of the house and lineage of David:) To be taxed with Mary his espoused wife, being great with child. And so it was, that while they were there, the days were accomplished that she should be delivered. And she brought forth her first-born son, and wrapped him in swaddling clothes, and laid him in a manger; because there was no room for them in the inn. And there were in the same country shepherds abiding in the field, keeping watch over their flock by night. And, lo, the angel of the Lord came upon them, and the glory of the Lord shone round about them: and they were sore afraid. And the angel said unto them, Fear not: for, behold I bring you good tidings of great joy, which shall be to all people. For unto you is born this day in the city of David a Saviour, which is Christ the Lord. And this shall be a sign unto you; Ye shall find the babe wrapped in swaddling clothes, lying in a manger. And suddenly there was with the angel a multitude of the heavenly host praising God, and saying, Glory to God in the highest, and on earth peace, good will toward men. And it came to pass, as the angels were gone away from them into heaven, the shepherds said one to another, Let us now go even unto Bethlehem, and see this thing which is come to pass, which the Lord hath made known unto us. And they came with haste, and found Mary, and Joseph, and the babe lying in a manger. And when they had seen it, they made known abroad the saying that was told them concerning this child. And all they that heard it wondered at those things which were told them by the shepherds. But Mary kept all these things, and pondered them in her heart. And the shepherds returned, glorifying and praising God for all the things that they had heard and seen, as it was told unto them.

"WE HAVE MANY ITEMS TO ADVERTISE,
BUT NONE AS IMPORTANT AS A HOPE FOR
PEACE ON EARTH AND GOOD WILL TO ALL MEN.
ONLY THROUGH CHRIST WILL THIS COME."

ANDERSON SURGICAL SUPPLY CO.

NEW YORK ACADEMY OF 2
MEDICINE
2 E 103RD ST
NEW YORK N Y 29 J C-E

Magnifies the rays of the sun...

...dispels the shadow of Rickets

Even in America today, surveys of certain groups reveal a surprising incidence of rickets.

To combat this danger, physicians realize the need for *regular* and *reliable* antirachitic measures.

A potent and economical source of vitamins A and D, Mead's Oleum Percomorphum has provided effective protection for millions of infants and children. For 17 years, physicians have placed faith in it.

Local Representative: Roger J. McElroy, 3181 McDonald Street, Coconut Grove 33, Florida, 4-4124.

The Journal OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXIX JANUARY, 1953 No. 7

JAN 1953
LIBRARY

IN THIS ISSUE

Use of Prostheses in Head and Neck of Femur
Herschel G. Cole and Arthur H. Weiland

Headache Problem and Otolaryngologist
Mozart A. Lischkoff

Thoracic and Abdominal Aneurysms
H. Milton Rogers

Diabetic Neuropathy
Sidney Davidson

"Let's All Eat Dirt"
An Editorial

OFFICIAL PUBLICATION OF THE
FLORIDA MEDICAL ASSOCIATION

in the hands of the physician

Often the critical evaluation of the drug to be administered is as important to the patient's recovery as is the diagnosis of his condition. In each case correct procedures can be determined only by the physician.

CHLOROMYCETIN is eminent among drugs at the disposal of the medical profession. Clinical findings attest that, in the hands of the physician, this widely used, broad spectrum antibiotic has proved invaluable against a great variety of infectious disorders.

Chloromycetin®

notably effective, well tolerated, broad spectrum antibiotic

The many hundreds of clinical reports on CHLOROMYCETIN emphasize repeatedly its exceptional tolerance as demonstrated by the infrequent occurrence of even mild signs and symptoms of gastrointestinal distress and other side effects in patients receiving the drug.

Similarly, the broad clinical effectiveness of CHLOROMYCETIN has been established, and serious blood disorders following its use are rare. However, it is a potent therapeutic agent, and should not be used indiscriminately or for minor infections—and, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

CHLOROMYCETIN (chloramphenicol, Parke-Davis)
available in a variety of forms, including:
CHLOROMYCETIN Kapseals,® 250 mg., bottles of 16 and 100.
CHLOROMYCETIN Capsules, 100 mg., bottles of 25 and 100.
CHLOROMYCETIN Capsules, 50 mg., bottles of 25 and 100.
CHLOROMYCETIN Ophthalmic Ointment, 1%, ⅛-ounce collapsible tubes.
CHLOROMYCETIN Ophthalmic, 25 mg. dry powder for solution, individual vials with droppers.

MEDICAMENTA VERA

Parke, Davis & Company
DETROIT, MICHIGAN

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

Volume XXXIX JANUARY, 1953 No. 7

CONTENTS

SCIENTIFIC ARTICLES

The Use of Prostheses in the Head and Neck of the Femur, Herschel G. Cole M.D., and Arthur H. Weiland, M.D. 487
The Headache Problem and the Otolaryngologist, Mozart A. Lischkoff, M.D. 491
Healed Dissecting Thoracic Aneurysm, Coexisting with Saccular Thoracic Aneurysm and Ruptured Abdominal Aneurysm: Report of Case, H. Milton Rogers, M.D. 495
Diabetic Neuropathy, Sidney Davidson, M. D. 500
The Use of the Antihistamines as Local Anesthetic Agents, F. James Stubbart, M.D. 505
A Study of Medical Indigence Based Upon the State Cancer and Diabetes Control Program, Lorenzo L. Parks, M.D. 507

ABSTRACTS OF MEDICAL ARTICLES

Drs. Arthur J. Butt, Hawley H. Seiler, David W. Goddard, A. R. Hollender, S. B. Forbes, Maurice Rich, Maxwell M. Sayet, and Theodore F. Hahn, Jr. 512

EDITORIALS AND COMMENTARIES

"Let's All Eat Dirt" 517
New Horizons 518
Prescription Regulations 519
Human Poisoning from Toxaphene 519
North Florida Fair Exhibit 520
Korean Casualties 521
Southern Medical Association, Forty-Sixth Annual Meeting, Miami, November 10-13 521
Medical District Meetings 1952 524

GENERAL FEATURES

Officers and Committees 514
From Our President 516
Correspondence 526
State Board of Health 528
Medical Officers Returned 528
State News Items 529
Births and Deaths 530
Wanted — For Sale 531
New Members 531
Component Society Notes 532
Obituaries 533
Woman's Auxiliary 538
Books Received 539
Schedule of Meetings 545

This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

Mothers will thank you

Swollowed Whole

Chewed
Or in Food Or Liquid

Dissolved on Tongue

NEW FLAVORED

CHILDREN'S SIZE

BAYER ASPIRIN

We will be pleased to send samples on request

THE BAYER COMPANY DIVISION of Sterling Drug Inc.
1450 Broadway, New York 18, N. Y.

- The Best Tasting Aspirin You Con Prescribe.
- The Flavor Remains Stable Dawn to the Lost Tablet in the Bottle.
- 24 Tablet Bottle . . . 2½ gr. each 15¢

2½ gr. 1¼ gr.

Grooved Toblets—
Easily Halved.

. . . Part of Your "Overall" Pic

Luzier's

Hand Service

Changing times produce cha
ing standards. The limp
useless hand so much admi
during Victoria's era has go
probably forever. Today we take pride in our capable hands and we should give th
the care they deserve. Of course you will want to give yourself a weekly manicure,
daily attention is just as important. Hand Balm, used at night, in the morning, and ev
time your hands are in water, will protect them and keep them lovely. Call on your Lu
Cosmetic Consultant for our wonderful aids to nail and hand care.

Luzier's Fine Cosmetics and Perfumes

Are Distributed in Florida by:

PFEIFER & PFEIFER, DIVISIONAL DISTRIBUTORS

235 North Main Street

Phone: 3-3636, Orlando, Florida

DISTRICT DISTRIBUTORS

MARTHA MATTHEWS
Box 3754
St. Petersburg, Florida
Phone: 75-8242

LOUISE SMITH
1414 E. Central
Orlando, Florida
Phone: 7520

RUBY FATULA
Box 775
Orlando, Florida
Phone: 9898

REESE T. VERMILYA
Box 2334
West Palm Beach, Florida
Phone: 8069

MAY LUCAS
3404 Cherokee St.
Tampa 9, Florida
Phone: 62-6234

AGNES BRAMLETT
3875 Walsh St.
Jacksonville, Florida
Phone: 2-1575

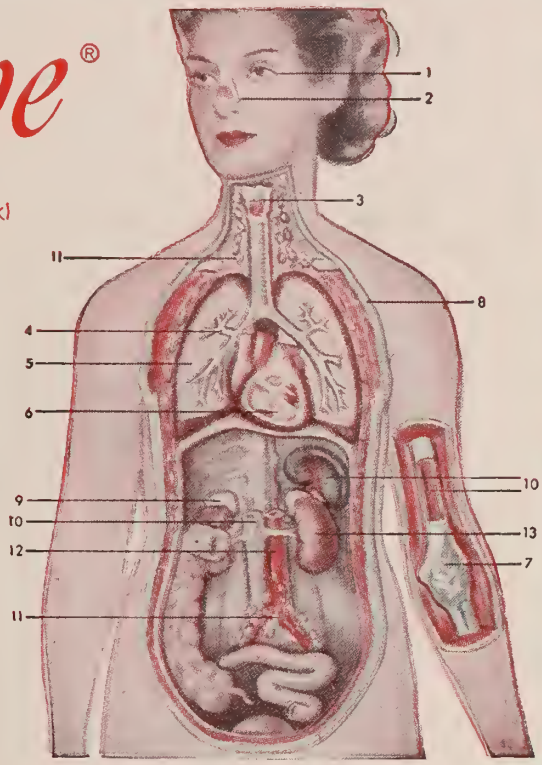
ROBERTA CHATEAUNEUF
1419 West Ave.
Miami Beach, Florida
Phone: 58-7407

Cortone®

ACETATE

(CORTISONE ACETATE, MERCK)

The many indications for CORTONE *highlight its therapeutic importance in everyday practice*



Primary Site of Pathology and Indications

1. EYE—Inflammatory eye disease. **2. NOSE**—Intractable hay fever. **3. LARYNX**—Laryngeal edema (allergic). **4. BRONCHI**—Intractable bronchial asthma. **5. LUNG**—Sarcoidosis. **6. HEART**—Acute rheumatic fever with carditis. **7. BONES AND JOINTS**—Rheumatoid arthritis; Rheumatoid spondylitis; Acute gouty arthritis; Still's Disease; Psoriatic arthritis. **8. SKIN AND CONNECTIVE TISSUE**—Pemphigus; Exfoliative dermatitis; Atopic dermatitis; Disseminated lupus erythematosus; Scleroderma (early); Dermatomyositis; Poison Ivy. **9. ADRENAL GLAND**—Congenital adrenal hyperplasia; Addison's Disease; Adrenalectomy for hypertension, Cushing's Syndrome, and neoplastic diseases. **10. BLOOD, BONE MARROW, AND SPLEEN**—Allergic purpura; Acute leukemia† (lymphocytic or granulocytic); Chronic lymphatic leukemia.† **11. LYMPH NODES**—Lymphosarcoma†; Hodgkin's Disease†. **12. ARTERIES AND CONNECTIVE TISSUE**—Periarteritis nodosa (early). **13. KIDNEY**—Nephrotic Syndrome, without uremia (to induce withdrawal diuresis). **14. VARIOUS TISSUES**—Sarcoidosis; Angioneurotic edema; Drug sensitization; Serum sickness; Waterhouse-Friderichsen Syndrome.

†Transient beneficial effects.

CORTONE *is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone.*

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY

"PREMARIN"®

Highly effective • Well tolerated • Imparts a feeling of well-being

"PREMARIN"

The menopausal patient
welcomes the sense of well-being
imparted by "Premarin."

"PREMARIN"

Estrogenic Substances (water-soluble)

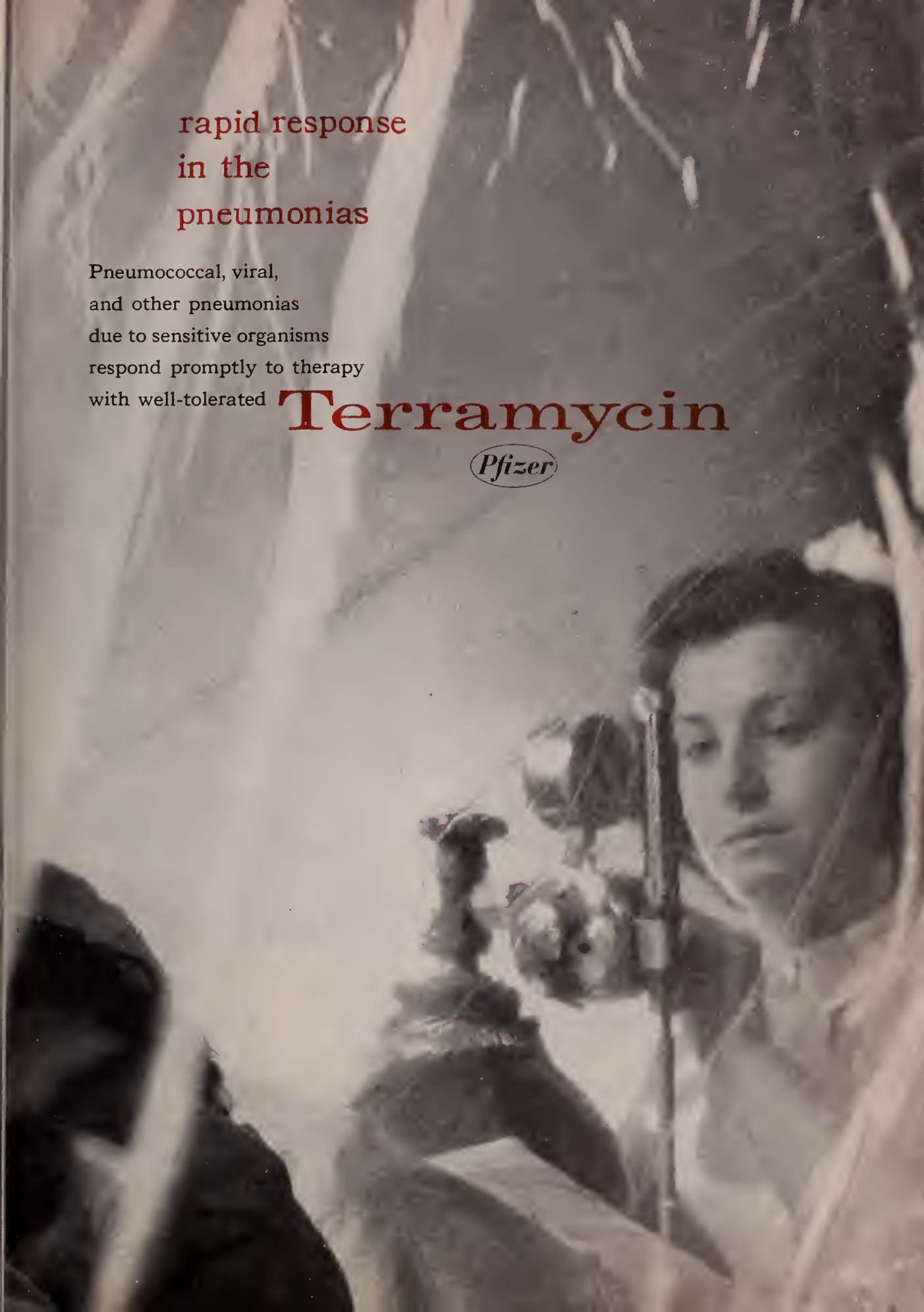
"PREMARIN"

also known as Conjugated Estrogens (equine)

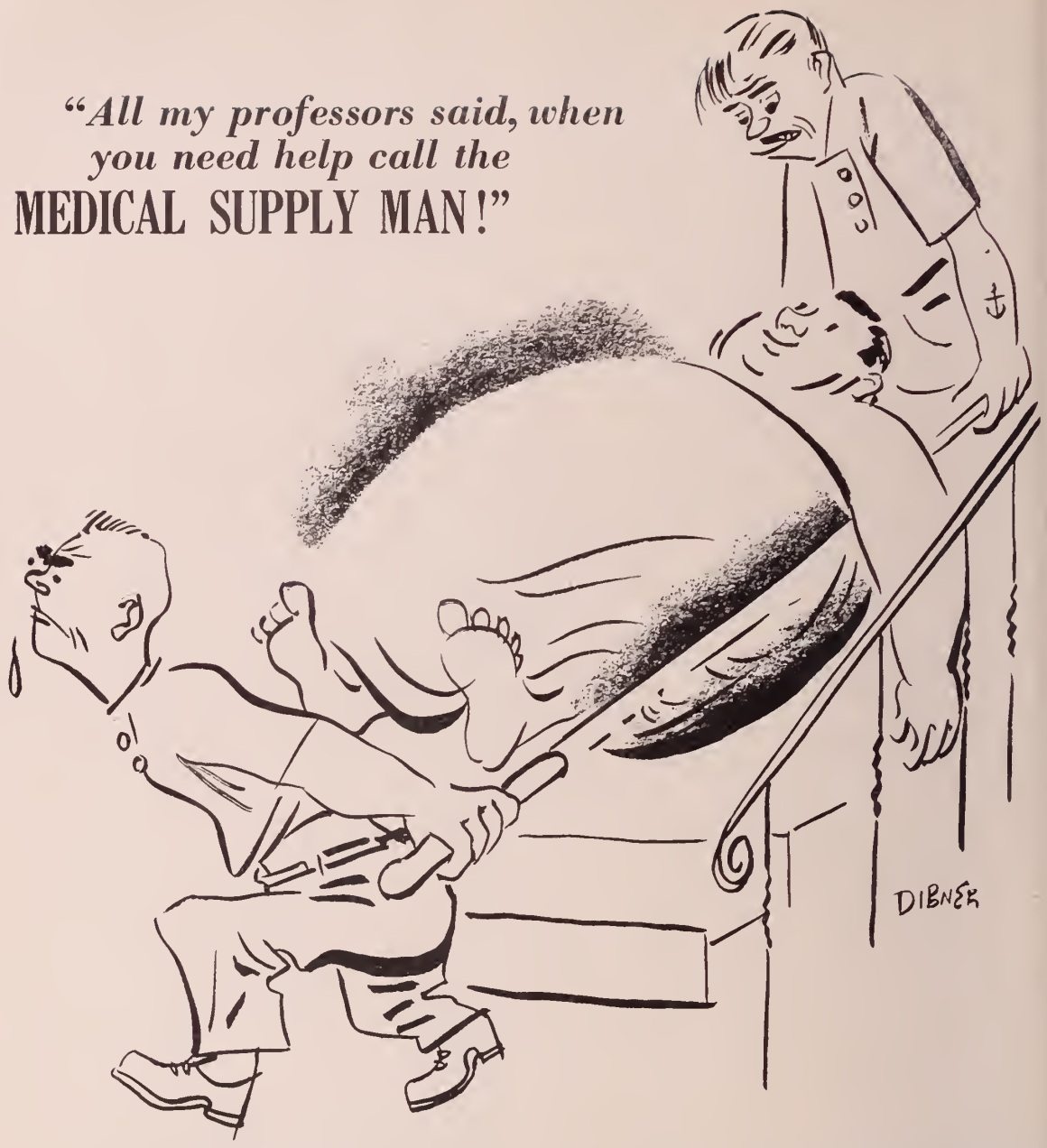
"PREMARIN"

5209

AYERST, McKENNA & HARRISON Limited • New York, N. Y. • Montreal, Canada


rapid response
in the
pneumonias
Pneumococcal, viral,
and other pneumonias
due to sensitive organisms
respond promptly to therapy
with well-tolerated
Terramycin
Pfizer

"All my professors said, when you need help call the
MEDICAL SUPPLY MAN!"



Good advice, too! In most cases, anyway. For instance, if it's equipment you need, Medical Supply Company has instruments and other equipment from over 500 manufacturers in stock at all times.

And if it's a supply problem you're facing, we have ample stocks of almost anything you want. In fact, we'd be glad to tell you about our inventory-control plan that can save you time, money, and effort.

Any mechanical apparatus gets out of order sometimes—and so we have a skilled staff of experts ready to put yours back in working order, adjusted to function just the way you want it.

If we can help you in any one of these ways, at any time, just CALL THE MEDICAL SUPPLY MAN —he'll come a-running.

HOSPITAL, PHYSICIANS and LABORATORY SUPPLIES & EQUIPMENT

MEDICAL SUPPLY COMPANY

Essentials For Scientific Progress

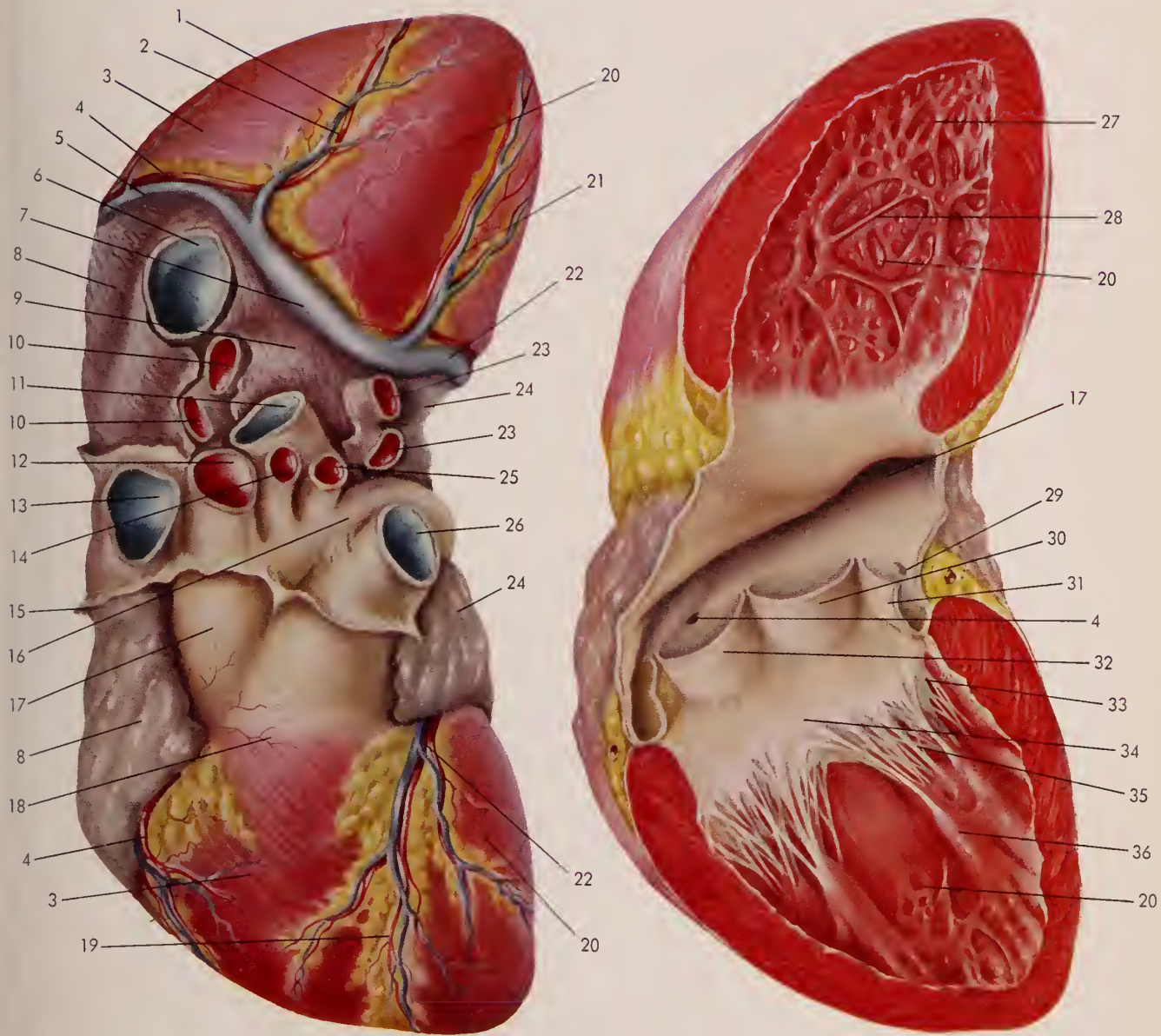
MIAMI • of JACKSONVILLE • ORLANDO

230 N. E. THIRD ST.
MIAMI 32, FLA.

420 WEST MONROE ST.
JACKSONVILLE 2, FLA.

329 N. ORANGE AVE.
ORLANDO, FLA.

Anatomy *of the* Heart



1 Middle cardiac vein
2 Posterior descending branch of right coronary artery
3 Right ventricle
4 Right coronary artery
5 Small cardiac vein
6 Inferior vena cava
7 Coronary sinus
8 Right auricle
9 Left atrium
10 Right pulmonary vein
11 Right branch of pulmonary artery
12 Innominate artery
13 Superior vena cava
14 Left common carotid artery
15 Pericardium
16 Aortic arch
17 Ascending aorta
18 Conus arteriosus
19 Anterior descending branch of left coronary artery
20 Left ventricle
21 Posterior vein of left ventricle
22 Great cardiac vein
23 Left pulmonary vein
24 Left auricle
25 Left subclavian artery
26 Left branch of pulmonary artery
27 Trabeculae carneae
28 Trabecula tendinea
29 Left coronary artery
30 Posterior semilunar valve
31 Left semilunar valve
32 Right semilunar valve
33 Posterior cusp of mitral (bicuspid) valve
34 Anterior cusp of mitral (bicuspid) valve
35 Chordae tendineae
36 Papillary muscle

This is one of a series of paintings by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.

Aureomycin

HYDROCHLORIDE CRYSTALLINE

in

Infections Involving the Heart

ENDOCARDITIS—Aureomycin has established itself as one of the most valuable agents available for the treatment of infections involving the heart. Aureomycin is now recognized as a highly effective antibiotic against the organisms most frequently encountered in endocarditis—staphylococci, *Str. viridans*, *Str. fecalis* and other enterococci. These organisms are being increasingly found resistant to penicillin and streptomycin. Endocarditis caused by these organisms has responded to aureomycin after failure of other antibiotics. Aureomycin is held by many physicians to be an antibiotic of choice for prophylactic use in patients with organic cardiac disease who require oral, intestinal, or rectal surgery, or any transurethral operative procedure. Endocarditis complicating typhus and brucellosis has responded well to aureomycin therapy.

PERICARDITIS—The importance of aureomycin in pericarditis has been demonstrated by its successful use after failure of other therapy—in acute nonspecific pericarditis, possibly of viral etiology; *H. influenzae* pericarditis; tularemic pericarditis; and actinomycotic pericarditis.

RHEUMATIC FEVER—Because aureomycin is an antibiotic with a wide range of effectiveness against the pathogenic strains of streptococci, its use has been recommended for the prevention of acute rheumatic fever and its cardiac complications.

* * *

PACKAGES: *Capsules:* 50 mg.–Vials of 25 and 100; 100 mg.–Vials of 25 and bottles of 100; 250 mg.–Vials of 16 and bottles of 100. *Ophthalmic Solution:* Vials of 25 mg.; solution prepared by adding 5 cc. distilled water.

LEDERLE LABORATORIES DIVISION

AMERICAN Cyanamid COMPANY

30 ROCKEFELLER PLAZA, NEW YORK 20, N.Y.

A bibliography of 39 selected references will be mailed on request.

Colt Today

CHAMP TOMORROW

Just as surely as pedigree and training make champions on the race track, so do other factors indicate the future of even small manufacturers of fine pharmaceuticals.

At *thirty years young,* having grown from modest loft quarters to a modern plant and laboratories, we are especially thankful for our *American heritage of free enterprise.*

This and your confidence assure our continued growth.

THE PAUL B. ELDER CO., BRYAN, OHIO
Manufacturers of Fine Pharmaceuticals

MAIL THIS COUPON FOR CATALOG

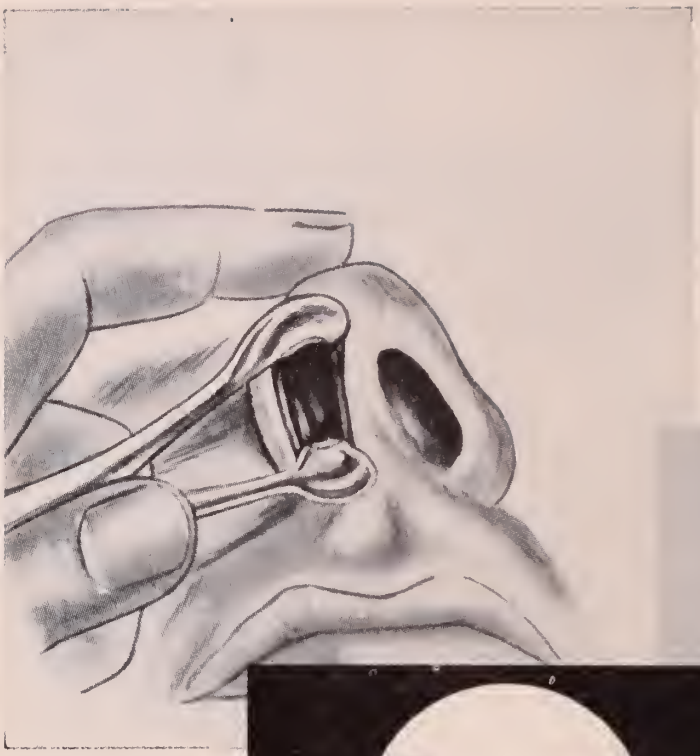
Paul B. Elder Company
Bryan, Ohio

Please send me your catalog of pharmaceuticals.

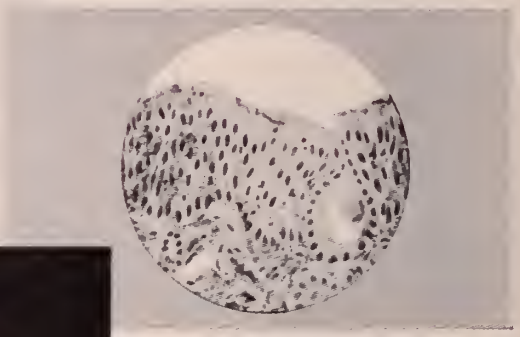
Signed_____ M D

Address_____

City_____



prompt and prolonged decongestion in **COLDS ...SINUSITIS**



Neo-Synephrine hydrochloride, through immediate and prolonged decongestive action, not only restores nasal patency, but also helps to reestablish and protect the physiologic defense mechanisms of the nasal cavity: sinus drainage and aeration.

Neo-Synephrine hydrochloride is notable for its relative freedom from sting and for virtual absence of compensatory congestion. Furthermore, it does not usually produce systemic side effects such as nervous excitation, cardiac reaction or insomnia.

The decongestive action of Neo-Synephrine hydrochloride is undiminished by repeated use—insuring relief throughout the duration of the illness.

¼% solution (plain and aromatic), 1 oz. bottles
½ and 1% solutions (when stronger vasoconstrictive action is needed), 1 oz. bottles
½% water soluble jelly, ⅝ oz. tubes

Neo-Synephrine®

HYDROCHLORIDE

Winthrop-Stearns INC
NEW YORK 18, N. Y WINDSOR, ONT.

Neo-Synephrine, trademark reg. U. S. & Canada, brand of phenylephrine

An Unsurpassed Estrogen Therapy

Small dosage makes ESTINYL inimitable among orally effective estrogens. As little as *two hundredths of a milligram daily* relieves menopausal symptoms and produces a sense of well-being obtainable only with larger doses of other estrogens.

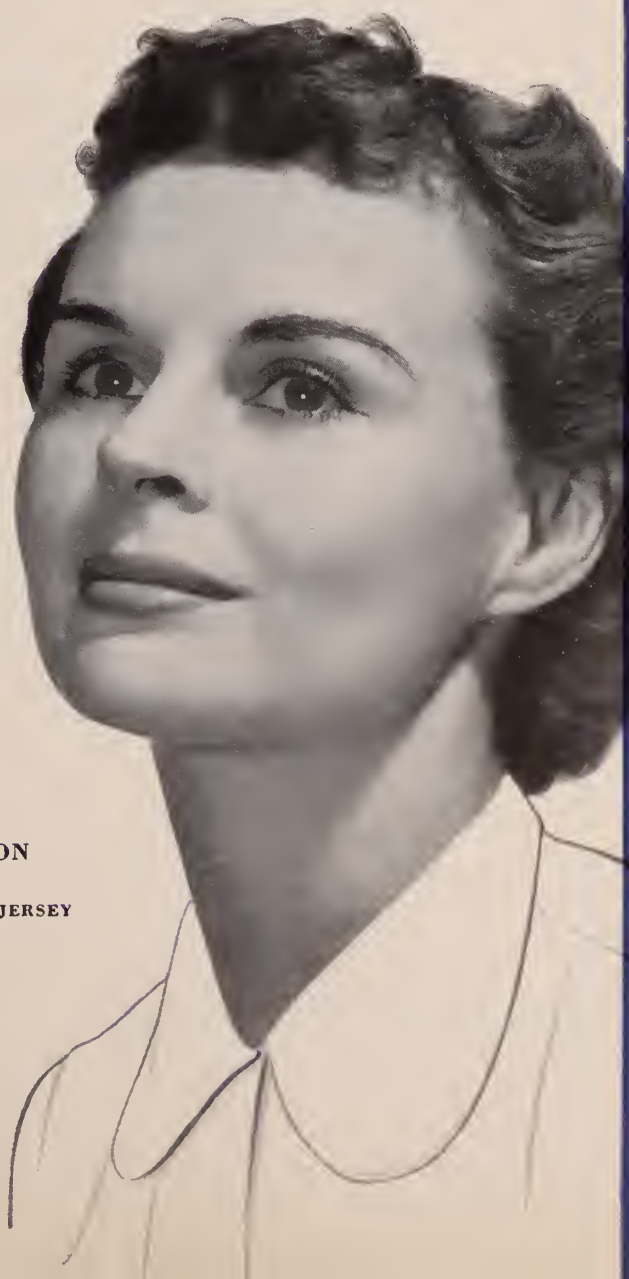
ESTINYL®

(ethinyl estradiol-Schering)

Available for treatment of menopause and other estrogen deficiency states, in tablets of 0.02, 0.05 and 0.5 mg.

Schering CORPORATION

BLOOMFIELD • NEW JERSEY



ESTINYL

still winning new friends

right through the menopause

on oral estrogen therapy that imparts

no odor or after-odor, no taste or after-taste

YOUR prudent and assuring explanations will help—clearing away the jungle of her doubts and fears. Then SULESTREX will help—in controlling the physical symptoms of the climacteric.

Years of search have given you SULESTREX—an odorless, absolutely pure, crystalline estrogen, chemically standardized for unvarying hormonal activity. Unexcelled—therapeutically *and* esthetically—these tiny uncoated tablets will never insult the breath or perspiration, never annoy with "after-taste."

A new report by Reich and associates[1] confirms and extends his conclusions from his pilot study[2]...

"Piperazine estrone sulfate (SULESTREX) *is a clinically effective oral estrogenic substance, easy to administer and extremely well tolerated. Its action is accompanied with an amazingly low incidence of side reactions."*

175 patients were included in this latest study, 50 of whom received therapy to relieve postpartum breast engorgement.

Make your own test—on your next menopausal patient. One trial will give impressive argument for this newest advance in oral estrogen therapy. SULESTREX is available in 0.75-, 1.5-, and 3-mg. grooved tablets.

Abbott

Sulestrex®

piperazine tablets

(PIPERAZINE ESTRONE SULFATE, ABBOTT)

1. Reich, W. J., et al. (1952), A Recent Advance in Estrogen Therapy. II. Amer. J. Obst. & Gynec., 64:174, July. 2. Reich, W. J., et al. (1951), A Recent Advance in Estrogen Therapy. I. Amer. J. Obst. & Gynec., 62:427, August.

1-61

Upjohn

less-antigenic penicillin:

Cer-O-Cillin

Trademark Reg. U. S. Pat. Off.

POTASSIUM

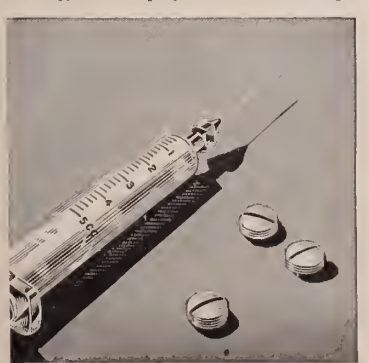
ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY

Available as:

Sterile vials containing 200,000 units Crystalline Penicillin O Potassium

Bottles of 12 buffered tablets, each containing 100,000 units Crystalline Penicillin O Potassium

The Upjohn Company, Kalamazoo, Michigan



The Right to *Choose* . . . .

CORNERSTONE OF AMERICAN LIBERTY

Hospital Expense Plans

Medical-Surgical Expense Plans

Paycheck Protection Plans

Life Insurance Plan

AS long as Americans keep the right to choose — their church, their political party, their doctor and their hospital — freedom must prevail.

We are proud that hundreds of thousands of Americans have freely chosen the protection afforded them by PENNSYLVANIA LIFE'S liberal, low-cost health insurance plan.

The Pennsylvania Life Insurance Company

HEALTH & ACCIDENT

FOUNDED 1890

HOME OFFICE: PHILADELPHIA 5, PA.

19 District Offices in Florida

Miami	Executive Office	3028 Biscayne Blvd.	
	Downtown	1210 Pacific Building	
	Southwest	1260 S. W. 22nd Street	
	Little River	8340 N.E. Second Ave., Suite 245	
	Coral Gables	3028 Biscayne Blvd.	
	Miami Beach	206 Harvey Building	
St. Petersburg		509 White Building	
Lakeland		206 Marble Arcade	
West Palm Beach		305 Citizens Building	
Orlando		209 Slayton Building	
Fort Lauderdale		521½ South Andrew Avenue	
Jacksonville		303 Clark Building	
Tampa		228 Cass Street Arcade Building	
Sarasota		237 Main Street, Room 15	
Fort Pierce		Florida Bank Building, Room 34	
Daytona Beach		116½ Orange Avenue	
Tallahassee		429 Centennial Building	
Panama City		142 Harrison Avenue	
Pensacola		501 Theisen Building	

Apresoline™

Hydrochloride
(brand of hydralazine hydrochloride)

for Control of Hypertension

For better individualization of dosage with Apresoline, a new, 10-mg. tablet has been added to the 25-mg. and 50-mg. potencies.

Apresoline is a relatively safe, *single* antihypertensive drug with minimal side effects, providing benefits in many cases—complete control in some. It is recommended that Apresoline be used in severe hypertension and in those mild hypertensive patients who have not been adequately controlled by conventional regimens (diet, mild sedation, rest, etc.). The following considerations are important:

Effective in essential hypertension with relatively fixed levels, early malignant hypertension, toxemias of pregnancy, and acute glomerulonephritis.

Induces gradual and sustained reduction of blood pressure with no dangerous, abrupt fall on oral administration.

Affords uniform rate of absorption and marked antihypertensive effectiveness.

Increases renal plasma flow in marked contrast to the decrease associated with certain other hypotensive drugs.

Produces significant relaxation of cerebral vascular tone without decrease in cerebral blood flow.

Side effects are minimal and often disappear as therapy is continued.

Complete information regarding manner of use and clinical application available on request.

Ciba

Ciba Pharmaceutical Products, Inc., Summit, New Jersey

2/1804M

the new

WELL-TOLERATED

wide-range antibiotic

'Ilotycin' is a powerful antibacterial of proved effectiveness* in the treatment of infections due to:

ORGANISMS	INFECTIONS
1. Staphylococci	Bacteremia, meningitis, pneumonia, osteomyelitis
2. Hemolytic streptococci	Cellulitis, erysipelas, peritonsillar abscess, pharyngitis, pneumonia, scarlet fever, septic sore throat, tonsillitis, wound infections
3. Pneumococci	Empyema, lobar pneumonia
4. Corynebacterium diphtheriae	Diphtheria carriers
5. Nonhemolytic streptococci	Some cases of endocarditis, genito-urinary tract infections

*References

1. Heilman, F. R., Herrell, W. E., Wellman, W. E., and Geraci, J. E.: Some Laboratory and Clinical Observations on a New Antibiotic, Erythromycin ('Ilotycin'), Proc. Staff Meet., Mayo Clin., *27*:285 (July 16), 1952. 2. Haight, T. H., and Finland, M.: Laboratory and Clinical Studies on Erythromycin, New England J. Med., *247*:227 (August 14), 1952. 3. Smith, J. W., Dyke, R. W., and Griffith, R. S.: Erythromycin: Studies on Absorption Following Oral Administration and on Treatment of 33 Patients, to be published. 4. Spink, W. W.: Personal communications. 5. Romansky, M. J.: Personal communications.

Lilly

ILOTYCIN
(ERYTHROMYCIN, LILLY)

DOSAGE: Adults—Total daily doses of 400 to 2,000 mg. are recommended, depending on the type and severity of the infection. Lobar pneumonia, bronchopneumonia, and some of the milder types of respiratory infections caused by organisms susceptible to 'Ilotycin' have consistently responded to doses of 400 mg. every four to six hours. For other infections, larger doses of 300 to 500 mg. every six to eight hours should be employed.
Children—6 to 8 mg. per Kg. of body weight every six hours.
Therapy should be continued for at least forty-eight hours after the temperature has returned to normal and acute symptoms have subsided.
Available in 100-mg. specially coated tablets in bottles of 36.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXIX | Jacksonville, Florida, January, 1953 | No. 7

The Use of Prostheses in the Head and Neck of the Femur

HERSCHEL G. COLE, M.D.
TAMPA
AND
ARTHUR H. WEILAND, M.D.
CORAL GABLES

The sole purpose of this presentation is to review the newer developments in the treatment of pathologic conditions of the hip resulting from old ununited fractures of the neck of the femur and osteoarthritis with pain or ankylosis, as well as the occasional old untreated dislocation of the head of the femur.

In this discussion it is proposed to treat the subject so as to be of interest to the medical profession as a whole and not alone to the specialists. Consequently, some details of the surgical technics will be omitted.

The stimulus given by World War II and the Korean War to the development of new mechanical devices and plastic materials has not been without its boon to the medical world, particularly as applied to orthopedic surgery.

For many years various types of metals have been used as means of internal fixation and incorporated in body tissue for long periods of time. Recent research developments, however, have aided in the production of metals and plastics that are completely inert, have no electrolytic action, and cause no necrosis of the bone. These substances are vitallium, stainless steel, and methyl polymethacrylate.

Formerly a fracture of the neck of the femur frequently resulted in premature death of the patient from hypostatic pneumonia following the application of a body case, or the complete absorption and death of the neck and head of the femur, making the patient an invalid, with prolonged suffering and disability. In many cases, although at the time of injury the fracture was accurately reduced and fixed with a metal pin, the head and neck of the femur would undergo aseptic necrosis in a few months. This situation is a direct result of the destruction of the blood supply to the neck and head of the femur, which even in a normal person is poor. When such a situation develops, it is accompanied by pain and the inability of the patient to walk and pursue his or her normal habits of life.

Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 28, 1952.

Reconstructive Procedures

For years surgeons have sought means to combat this condition and to alleviate the pain and disability occurring after the death and absorption of the neck and head of the femur, but until recently such procedures involved the surgical sectioning of the shaft of the bone, accompanied by pushing it over beneath the head to form, at best, a natural crutch by fibrous or bony union. In some cases it worked well, but in many instances it was wholly unsatisfactory.

The McMurry osteotomy is an example of this procedure. Reconstructive operations of various types, particularly those described by Whitman and Colonna, have also been used with varying degrees of success or failure. Frequently the patient has been given the choice of one of these procedures or an operative fusion of the hip, which at best could result in a painless weight-bearing extremity but a joint with no motion.

In more recent years Dr. Smith-Peterson of Boston brought into existence the use of the vitallium cup operation, which was a further improvement but far from satisfactory. This did, however, give a great stimulus to the idea of the present prosthesis.

In the Journal of Bone and Joint Surgery, British Edition of May 1950, Drs. Jean and Robert Judet of Paris, France gave a compre-

hensive and modest report of the use of plastic materials for replacement of the head and neck of the femur, which had followed an aseptic necrosis as the result of fracture. The series included 300 cases since 1946 of painful osteoarthritis, old congenital dislocations of the hip accompanied by pain, and ankylosis of the hip joint due to various organic diseases.

Figure 1.

A stainless steel metallic femoral head and neck was developed by Dr. Jaenichen and first used by him in 1947. Mr. Collison, an engineer now deceased, materially assisted in the mechanical development of this device, which now carries the name of Jaenichen-Collison Head. Likewise, previous to that time numerous other artificial prostheses had been used, which had for their main purpose inserting the fixation bar down the medullary canal of the proximal portion of the femur.

Our experience has been confined to the use of the Jaenichen-Collison stainless steel head and neck and to the plastic type, which the Drs. Judet introduced.

The plastic device gives the appearance of a mushroom, the stem of which is reinforced by an encased piece of stainless steel to prevent breaking. The application is effected after the removal of the dead bone, consisting of the head and neck, by the drilling of a hole and driving the stem of the prosthesis into the remaining portion of the neck. Before insertion of the prosthesis, the remaining portion of the neck of the femur is rounded off and grooved with a special instrument to be inserted into the cuplike under surface of the plastic head. The stem then should protrude to the outer cortex of the femur, and if it extrudes somewhat, one need not worry, as it may be excised by the use of a bone saw. Care should be used not to attempt to cut it with bone-cutting forceps, as such an attempt will crack the material.

The application of the Jaenichen-Collison stainless steel prosthesis is much more of a technical surgical procedure and a more shocking operation, in that there is necessitated the application of a receptacle femoral plate that requires much more surgical skill. More commonly the surgical approach used in cases of this type is the Smith-Peterson approach or a modification of this incision. The posterior approach is becoming rather popular, however, and may prove to be the most satisfactory.

There are those who advocate a complete removal of the joint capsule, sustaining the opinion by the argument that it serves to cause less painful postoperative hips, on the basis of a neurectomy, and that it will likewise prevent the calcification of the capsule with a tendency to form a bony block between the acetabulum and the trochanter. We believe only that portion of the capsule which is readily available should be removed and have had no difficulty in our cases.

Fig. 2. — Jaenichen-Collison prosthesis—working model.

The necrotic head of the femur is then removed in the usual procedure, with care being taken not to injure any remaining portion of the joint cartilage. Some surgeons routinely use a reamer to remove all the cartilage, but in our experience,

unless there are osteophytes present or a pronounced roughening of the articular surface of the acetabular fossa, this procedure is not necessary.

Fig. 3. — Mrs. A., aged 51. Six months after insertion of Smith-Peterson nail.

The Judet prosthesis has the advantage of a relatively easy application in comparison to some of the other prostheses used; however, it does not restore the excised portion of the neck of the femur and results in a shortening.

Postoperatively, the use of hip prostheses has distinct advantages over any of the other reconstructive procedures, in that the period of postoperative recovery is much shorter and weight bearing is allowed within three weeks, as no bony union is required.

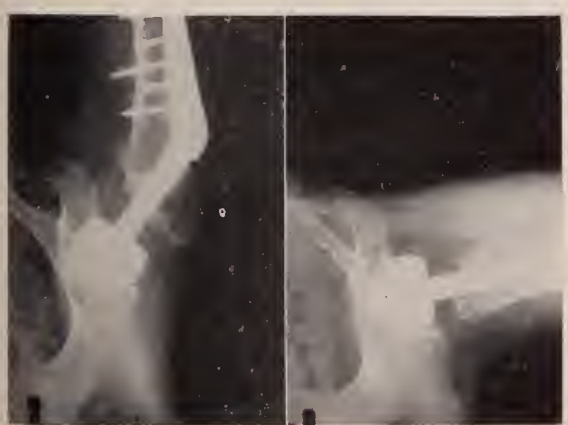


Fig. 4. — Mrs. A. Postoperative roentgenograms after insertion of Jaenichen-Collison prosthesis.

Complications

One of the complications that might be anticipated as a surgical postoperative problem following application of the prosthetic apparatus, particularly the short neck or mushroom type, is anterior dislocation of the head of the femur. To overcome this, we are of the opinion that as little dissection in the surgical procedure as can be done is advisable and that postoperatively the legs should be placed in internal rotation and abduction, being held for a period of three weeks, to allow for soft tissue healing.

Of course the usual postoperative complications, such as phlebitis and embolism, can occur in this procedure as in any other.

It is our opinion that old age is no barrier to this procedure. Many hold, and we sometimes favor the opinion, that in capital or subcapital fractures, in all probability it would be better to remove the head of the femur immediately and at once insert the prosthesis. Doing so would markedly shorten the period of convalescence in comparison to that required upon employment of those methods dependent upon bony union, which often ends in subsequent absorption of the neck and head and further surgery, about which we are now concerned. This observation is also true of vertical fractures of the femoral neck.

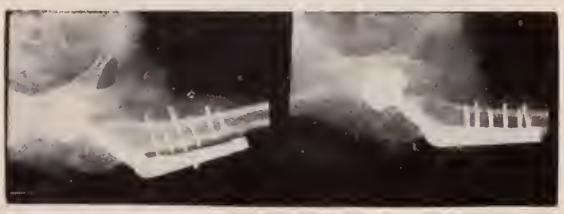


Figure 5 *Figure 6*

Fig. 5. — Twenty months after application of prosthesis — all screws broken and plate pushed away from shaft.

Fig. 6. — Two and one-half months later. New plate applied with shortened femoral plate neck. Note head rests against neck.

There is one comment we should like to make regarding the relatively long period of hospitalization of the elderly patient. Not infrequently in such a patient there will develop a postoperative acute psychosis. We find the almost complete and universal cure is to remove him immediately to his home, among his family, friends and familiar surroundings, provided of course his care can be adequately conducted there.

The surgical procedures involving prostheses would not be feasible save for the developments in chemotherapy and the antibiotics. We now enter a field of surgery where we formerly feared to tread.

In every case active supportive treatment of the general condition of the patient prior to operation is imperative, and particularly in regard to preoperative blood transfusions as well as frequent small ones postoperatively.

Personally, I have used hip prostheses in 11 cases (figs. 1-8), the first, two years and three months ago. All involved complications following fractures of the neck of the femur. In 1 case in which the plastic prosthesis was used, infection followed a near fatal urinary infection, and it was removed. In 2 cases the screws in the femoral plate of the Jaenichen-Collison metal prosthesis broke, due to fatigue of the screws, allowing the plate to pull away from the femoral shaft (figs. 5 and 6). One plate was replaced with good results; the other is to be replaced soon.

Fig. 7.— Mr. B., aged 48. Head removed due to acute trauma six months previously. Thrombophlebitis complication.

In closing I wish to state that I believe that the experiences of various surgeons throughout the country tend to prove that a tremendous advancement in hip surgery has been made.

I feel honored to have been associated with Dr. Arthur H. Weiland in the presentation of this subject.

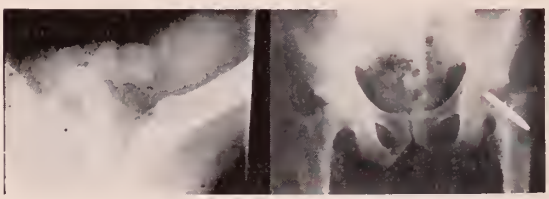


Fig. 8.— Application of Judet plastic head.

Finally, I wish to acknowledge publicly my especial gratitude to Dr. John F. Lovejoy of Jacksonville, who, I believe, was the first to perform this procedure in Florida some three and one-half years ago. His kind assistance to me when I first became interested in this subject has been invaluable.

References

Judet, J., and Judet, R.: Use of Artifical Femoral Head for Arthroplasty of Hip Joint, J. Bone & Joint Surg. 32B:166-173 (May) 1950.

Peterson, L. T.: The Use of a Metallic Femoral Head, J. Bone & Joint Surg. 33:65-75 (Jan.) 1951.

1102 West Cass Street.

Discussion

DR. ARTHUR H. WEILAND, Coral Gables: This presentation is not designed to give any particular end results with this procedure. I should like to stress the fact that it is a brand new procedure, and we do not know yet just what the final decision is going to be. There are those who have performed a good many procedures of this type over a much longer period of time than we have, and I believe that they still believe about the final report much as we have told you here. In our group we have had 16 cases, the oldest one about a year and nine months ago. We have had one fatality, a cardiac death after the prosthesis was put in and no fault of the operation or of the prosthesis. We have used the Collison device exclusively.

I was interested several months ago in looking at a presentation of Dr. Paul Steel of Pittsburgh, who presented 26 cases of prosthesis, not with the same type of head that we are using, and he repeatedly stated as he presented the slides that it looked as though in many of his cases there was an anterior subluxation. I believe that when we use this procedure, if we make an effort to put the metal shaft just a bit posterior to center of the anatomic neck, we will avoid entirely the tendency to an anterior luxation. As a matter of fact, in most of the cases, if we put the shaft in accurately just posterior to center of the neck, we do not even have to keep the hip over in internal rotation. The advantage here, as Dr. Cole pointed out, is that the patient can get up and start walking in three weeks' time.

All of these slides look much alike. I am presenting one case here simply to illustrate a point. The patient, aged 15, was accidentally shot in the hip at close range with a shotgun in 1945. You will notice in this first slide all of the shot still imbedded in the soft tissues about the hip. When I first operated on him late in 1945, some time after the injury took place, I found fragments of clothing, the wad of the shell and numerous pieces of debris within the wound. It was suppurating freely. There were deposits of shot in various areas about the hip, and I cleaned out as much as I could. Subsequently, I went in again and removed fragments of dead bone, further debris and as many of the shot as I could find. The wound eventually closed and remained closed for about two years and three months.

The patient was a rather vigorous young chap. His father and the boy himself were extremely desirous of establishing motion in the hip. You will notice that in this roentgenogram the hip is firmly ankylosed. He had a painless weight-bearing extremity, but he had a stiff hip, which incapacitated him a good deal. They desired to have some procedure attempted which would re-establish motion in the hip. I told them about the prosthetic device and warned them at the time that we might run into difficulty if we attempted any type of operative procedure on the hip regardless of the fact that there had been no drainage for about two years and three months.

Five months ago I performed the prosthetic operation, and here is the postoperative roentgenogram. Ten days following the operative procedure without much rise in temperature, less than 1 degree, there was established a draining sinus over the anterolateral aspect of the hip, which drained a considerable amount of purulent material. Antibiotics were administered, and over the ensuing 30 days the drainage subsided and the wound closed. It again opened about two weeks later and drained for approximately two weeks. Since then it has remained closed, but as we have attempted to rehabilitate the patient, when he bears much weight on the extremity, or if the physical therapy department attempts a great deal of motion, there develops an inflamed area over the region of the previous sinus. Although it is not broken down, we are exceedingly fearful that it will break down and we may have to go in and remove the prosthetic device entirely.

He has a fair range of motion, but as I say, his activities have had to be limited because of the fear of breaking down of the wound. I simply present this slide in this particular case to illustrate that it is perhaps not too good judgment to attempt to put in a device of this kind in an area where there are foreign bodies and where there has been previous infection.

As far as the cases on which this procedure might be employed are concerned, I believe that I would have no hesitancy in performing a primary operation of this type on a vertical fracture of the femoral neck or on capital fractures and subcapital fractures. I believe it is a time saver, and it does not necessitate the long period of bed rest that the other operative procedures do.

Dr. John F. Lovejoy, Jacksonville: I have enjoyed this discussion because I have been interested in this subject for some time. We in medicine are a privileged group of people. We have quite a stewardship for human beings. That stewardship has been given to us by a grateful public because it has been a well handled stewardship for the most part. Now we in orthopedics have a little further responsibility in that most of our practice is constructive or reconstructive, and differs a bit from the general surgery which "cuts out" and throws away.

Prostheses are not new. Man has been using something in a prosthetic way ever since he first injured himself, such as an artificial leg to get him about. History also shows that back in the time of Napoleon's Josephine "falsies" were used, and I think you will find that they too are here to stay. Internal prostheses are not quite so old. They have been used a little longer than we have used them in orthopedics perhaps by the brain surgeons who have used plates in the skull, and for the cosmetic effect by the urologist with the removal of a testicle and replacement, and probably for many other purposes.

The problem of prostheses of a hip, however, which we are primarily discussing today, goes back to about the time of the first metal plates. When the Sherman plates were put in, thinking got started along that line, and the first ones I actually know of were used by Dr. Bohlman in Baltimore somewhere around 1927. There are many different types unfortunately, too many on the market. They are a lot of gadgets. The prosthetic program has been launched, wisely or unwisely, time alone will tell.

I started with Mr. Collison in this work back in 1947, and I wish I had time to pay tribute to the man that he deserves. He was an engineer and not a physician, and working technically with physicians was a hard problem because I do not know of any more hard-headed group than we are. Nevertheless, he was able to go through with it, learn a little physiology and leave some of his imprint of mechanics on some of us who had the privilege of working with him. Suffice it to say that his death was untimely and his loss was great.

I have had 14 cases in which I have used the Jaenichen-Collison device and about 6 in which I have used the Judet hip. My results are not all good. In my oldest case the patient was a girl 16 years of age when the device was put in and she is now on her sixth year. She has been married and has a baby since, and walks well with a cane. I have had 2 cases in which the wound drained and eventually healed. In 4, the screws have broken, and we have replaced them. I have put the "collars" in each time after replacement. I do not believe that removal of the cartilage of the acetabulum is a pain-producing procedure, and I think it should be done as the cartilage atrophies anyway and has to be absorbed. The principle of the Collison type of hip or the Jaenichen-Collison type of hip with its metal shaft holding the neck in line I think is a sound principle and gives it an advantage over the other prostheses that are on the market today. The principle of attaching it to the shaft where there is an inert metal against a living material is still the biggest problem. I agree with Dr. Weiland that when we can make that attachment adequate, we should employ the procedure as primary surgery in those in whom we know we will have to do it later anyway.

I am not so pleased with my Judet hips. I am convinced that the metal hips are a much more comfortable type of prosthesis than the plastic, and my experience has been with the acrylic and the nylon. I have 2 that are beginning to present a varus deformity in cutting out by the weight of the body against it. In my opinion, the principle of some other fixation besides the Judet type is of much greater value. I think that up to the present time this Collison shank with the neck fitting into it has a value. Whether it is the complete answer or not, I do not know. I think that the prostheses are here to stay and be developed. Only flagrant misuse would prevent their permanent use and development. I hope that we do not forget our stewardship and misuse something that has such value.

The Headache Problem and the Otolaryngologist

Mozart A. Lischkoff, M.D.
PENSACOLA

Headache is probably the commonest complaint to which the body is subject, next to constipation, and its universal occurrence has led many to attach little significance to it, especially when mild and transitory and occurring infrequently. Like any recurring symptom, however, it may be a warning, not to be overlooked. It may result from a wide variety of causes. Though seldom a matter of life and death, severe headache may be an emergency from the patient's point of view, and because he may demand or require immediate relief, a differential diagnosis may have to be postponed.

It is estimated that 50 per cent of all patients, encountered in general practice, suffer from headaches; yet headaches associated with sinusitis are relatively infrequent and have been estimated at 5 per cent by McDonald. Shea stated that 3 per cent are of sinus origin; yet headache is the commonest symptom for which a patient consults an otolaryngologist.

The headache of chronic sinusitis is the result

Read before the Eye, Ear, Nose and Throat Hospital Alumni Association, Second Annual Meeting, New Orleans, April 3, 1952.

of either toxemia or a change of the intrasinus pressure. The frontal headache of a frontal sinusitis is of the vacuum type, occurring one or two hours after one arises, and is limited to the distribution of the tritacial nerve. It may be relieved if the frontal sinus is drained or better ventilated.

McLaurin directed attention to the condition of the nasal cavities, paranasal sinuses and adjacent nerve structures as factors in otorhinologic headaches. He stated that the absence of pain proves nothing, but its presence, not the degree of pain, is important. He added that in sinus disease, faulty ventilation of the sinuses and intranasal pressure account for the greater number of headaches. Regardless of whether a vacuum is formed in a closed paranasal sinus, headache is likely to occur when the natural ostium is occluded.

Etiologic Classification

Headaches may be classified as being due to anatomic anomalies or to an inflammatory condition of the mucous membranes of the nose. The latter may be caused by catarrhal or purulent diseases of the paranasal sinuses.

Anatomic anomalies causing head pains may be any of the following: (1) a thickened or deflected septum, high up, impinging on the middle turbinate, especially when the latter is cystic; (2) impaction of the middle turbinate against the lateral nasal wall, thus interfering with the proper drainage of the ethmoid labyrinth on that side; or (3) a bulging ethmoid cell or a bulla ethmoidalis. Whether disease of the maxillary sinus causes headaches or not is still a matter of doubt. Often a patient is examined whose maxillary antrum is full of pus, but he does not complain of headache. Toxic headache may, however, be caused by absorption of enclosed pus from the antrum. Nasal obstruction apart from infection may be the cause of persistent frontal headache.

Any of these anomalies, singly or in combination, may interfere with adequate drainage and ventilation of the frontal sinus by pressure on a narrow nasofrontal duct. Air in the frontal sinuses is absorbed with a resulting vacuum headache. These irregularities are precipitated and aggravated by any inflammatory process in the nasal space. As time passes, hyperemia of the lining of the frontal sinus results, with all the concomitant symptoms of either an acute or a chronic purulent frontal sinusitis. The possibility of a vacuum headache must be borne in mind, negative radiographic evidence notwithstanding.

No classification of headaches or head pains is universally accepted, although various ones fairly parallel one another. Boies classified three main groups: those which are part of the picture of systemic or general disorders, those which are more or less independent of any local disease or general condition, and those which are the result of disorders within the head.

Proetz classified headaches as: Class A, those of definite demonstrable origin — regardless of the origin; Class B, those of semidemonstrable, or questionable, origin; and Class C, those of undemonstrable origin — the perplexing type.

There are many remote conditions provoking head pains, but the local mechanisms which produce them are (1) irritation of a sensory nerve or nerves; (2) vasodilatation from histamine produced by local tissue damage in response to physical or emotional stimuli; and (3) a change in cerebral blood volume, resulting in a stretching of pain-sensitive nervous structure along the blood vessels.

It should be remembered that a neuritis of the nasal nerve may exist coincidentally with other neuritides, and this head pain might be difficult to differentiate.

Ocular headaches result most frequently from uncorrected errors of refraction, but chronic glaucoma is a commonly overlooked etiologic factor. The eyes should never be overlooked in an investigation of headaches.

Many headaches are set off by a trigger mechanism such as a refractive error, sinus disease, infected or carious teeth. Fatigue and exhaustion also can cause a headache.

Migraine

Allergy is an important factor in migraine headache. It is one of the commonest periodic headaches, occurs in the first or second decade of life and is unilateral in character. It has been estimated that twelve million Americans have migraine and two to eight million in the United States are incapacitated temporarily by these headaches. About 50 per cent of the children of parents with migraine are subject to this type of headache.

The attacks are precipitated by worry, excitement or fatigue, are commonly associated with the menstrual cycle, but are unlike the gynecologic vascular headache occurring during menstruation, which is a reflex from a pelvic disorder. It is a prevalent headache, affecting about 8 per cent of all patients. Its characteristic vascular throbbing,

with a variable period of relief between attacks, differentiates it from the closely similar histamine cephalalgia.

Migraine starts with an aura in 10 per cent of cases, is unilateral at the onset, but becomes generalized and may be associated with irritability, depression, nausea and vomiting, constipation or diarrhea, and polyuria. The aura may be visual in type, as bright flashes, moving scotoma, or photophobia; or emotional with euphoria, hyperesthesia, or auditory hallucinations. The aura is caused by vasoconstriction of the intracranial cerebral arteries. It may last a few hours to several days, and the patient appears extremely ill. The migraine attack is caused by vasodilatation of the branches of the external carotid arteries.

Personality features and reactions dominant in persons with migraine are feelings of insecurity, with tension manifested by inflexibility, conscientiousness, meticulousness, perfectionism and resentment, which date back to their early childhood. In short, certain persons have a predisposition and the psychobiologic equipment which make them prone to certain pernicious emotional states. The emotional state of the patient affects the autonomic nervous system.

Any vasoconstrictor that can decrease the amplitude of pulsation by 50 per cent relieves the headache, provided it is given early. The ineffectiveness of vasoconstrictors late in the attack is due to edema of the vessel wall.

Lieder believed that hypersensitivity assumes a major role in causing migraine and that, in prophylaxis, identification and elimination of offending allergens, usually food, are important. In 28 of 52 patients with migraine he found definite evidence of food allergy.

The textbook migraine syndrome is characterized and differentiated from other chronic headaches by these special features: periodic, recurring, but definite attacks, often associated with nausea, vomiting, vertigo, visual disturbances, chilliness, pallor and tremor. Psychic disturbances are also common during the migraine attack. The attack is usually unilateral in onset, but may become generalized, and there is freedom from symptoms between attacks.

Wolff stated that the migraine headache attack is but one aspect of a diffuse disturbance in function occurring periodically during or immediately after a period of stress, and these psychogenic factors are as important as the somatic. It is treated with ergotamine tartrate, bed rest, dark room, and sometimes prolonged warm baths.

Ergotamine tartrate (gynergen), a potent vasoconstrictor, is the best drug to shorten the attack. Relief comes within the hour in 90 per cent of the cases. It should not be repeated within seven days. In cases without nausea the pills may be crushed and given sublingually.

Dihydroergotamine tartrate (D.H.E. 45) is better tolerated, causes less nausea, and produces less toxic uterine effect. The dose is 1.0 to 2.0 mg., the latter being preferable. Cafergone (E.C. 110), which is a combination of caffeine 100 mg. and ergotamine tartrate 1.0 mg., is a better form of treatment. This particular combination apparently acts in synergism and is effective in reducing the intensity of nervous responses to stimulating experiences. It is believed that caffeine produces vasoconstriction of the extracranial and intracranial vessels. The dose is two tablets at the onset, followed by 'one every thirty minutes two or three times, unless no relief occurs.'

Histamine Cephalalgia

It is possible that many patients treated for migraine are not suffering from migraine. There is a regrettable tendency to label any chronic, recurring headache as migraine, and it may be difficult to differentiate it from histamine cephalalgia. In the latter there is no heredity factor, and nausea, vomiting, and scotomas are absent. The attack lasts a short while, and the pain, which is severe, sudden and unilateral, occurs often during the middle of the night, awakening the patient. It usually recurs many times a day, extending over a period of days.

Horton described histamine cephalalgia as a vascular headache similar to migraine and caused by dilatation of the external carotid artery. It begins in the fourth or fifth decade, often is preceded by migraine in earlier years, and is sharp, throbbing and acute. One experiences an attack after retiring to bed or early in the morning, and it lasts a short time, maybe an hour or two. It occurs almost daily with periods of relapses. It is accompanied by vasomotor symptoms, such as heat sensations, sweating, lacrimation, rhinorrhea and nasal blocking. It is unilateral, and frequently begins in the forehead and temple with the occipital region often involved. It is due to lowered tolerance to histamine. Horton recommended a specific histamine desensitization procedure to relieve this type of headache. Cafegot has been employed effectively for symptomatic treatment.

Patients do well on desensitization. Actually

it is a misnomer, as histamine is not antigenic. Histamine therapy may increase the body tolerance to histamine. Patients are given initially 0.15 cc. of histamine acid phosphate (0.275 mg. in 1.0 cc.), with an increase of 0.05 cc. until a 1.0 cc. dose is reached. The injections are given twice a day, until twenty injections have been given and a maintenance dose is established.

Other Headaches

One of the commonest of all headaches is that caused by hypertonicity of the muscles of the neck. Forty per cent of early morning occipital headaches are thought to be caused by spinal arthritis. Psychoneurosis, however, is probably the commonest cause of occipital, suboccipital and cervical headaches. Muscle contraction headaches associated with anxiety and tension may occur coupled with other headaches, such as vascular headaches of migraine or those due to infection, inflammation, or other forms of noxious stimulation, including neoplastic invasion. Regardless of the cause, the clinical picture is similar and outstanding, with a feeling of tightness, and pain on brushing the hair or putting on a hat. Treatment consists of heat, massage, and maybe phenobarbital. The patient's dissatisfaction, anxiety and tension must be approached by psychotherapy.

Interval treatment must be aimed at removing or controlling the personality and emotional conflicts that are so prevalent, especially in most patients with migraine.

Drug therapy is also indicated if it can be directed toward dampening the responses of the autonomic nervous system. Bellergal, a combination of ergotamine tartrate, bellafoline and phenobarbital, has been used with good results. It relieves the psychosomatic symptoms and is a useful adjunct to psychotherapy.

Cerebral trauma or postconcussion headaches, endocrine disorders, intracranial lesions, blood dyscrasias, neuralgias, heredity tendencies and many other pain-producing mechanisms are responsible for pain felt within the head that may be classified as headaches. To arrive at a diagnosis, however, careful history-taking is especially important, and a thorough examination is absolutely necessary.

Even after a diagnosis has been made, the treatment is often of questionable value, and the approach to the problem presents considerable difficulty unless, and even if, a definite routine is outlined. To paraphrase the words and wisdom of Oliver Wendell Holmes, "If I wish to show a student the difficulties of medical practice, I should give him a headache to treat."

Range of Treatment

When the cause is known, the treatment consists in an attempt at removal, whether it is a sinus infection, eyestrain, or brain tumor. If the cause is not immediately apparent, or the diagnosis questionable, the patient may require occupational or social readjustments or some change in the daily living habits. It may mean giving up smoking or alcohol, improving the ventilation of living and sleeping quarters. Vasomotor rhinitis or nasal obstructions should be treated both for immediate and long range relief. Cervical myositis is treated with counter irritation, neuropsychiatric disorders should receive psychotherapy, and the dentist should correct the dental pathology. If the basal metabolic rate is low and the associated symptoms help to comprise a pattern of hypometabolism, thyroid may be helpful. During the climacteric or in the period of artificial menopause, the estrogens merit a trial.

Histamine diphosphate is usually effective in histamine cephalalgia and certain types of vascular headaches, and administration of nicotinic acid may produce excellent results. Heat and massage are useful and necessary. Salicylates relieve the pain of fibrositis, and novocain 1 per cent injected in the tender spots may start relaxation of the muscles and be effective for some time. The addition of hyaluronidase to spread the novocain is helpful.

Sedation with ergotamine tartrate is more than palliative with migraine. Two tablets of ergotamine with caffeine at the first sign of attack usually give relief. If the attack continues, one additional tablet every half hour up to six tablets should be given. This drug is contraindicated in organic heart disease, vascular disease, hypertension, renal or hepatic impairment and pregnancy, and is not curative. Dihydroergotamine methane sulfonate (D.H.E. 45) parenterally is as effective and less toxic.

Treatment by intravenous injections of histamine in 1 to 250,000 solution at the slow rate of 25 to 40 drops per minute while one watches for signs of flushing, with completion of the injection in from one to one and one-half hours, has relieved histamine cephalalgia that defied all previous treatments. Benadryl, 50 mg., is often helpful to terminate the histamine reaction and acts as a sedative.

Summary

From the standpoint of the otolaryngologist, the broad subject of headache is presented. Incidence, classification, etiologic considerations, diagnosis and the wide range of treatment are discussed.

Because headache is probably the commonest complaint of modern civilization, the diagnosis and treatment will continue to be a problem to plague the practicing physician in every specialty.

References

Ayash, J. J.: Headache and Headache Pain. Journal Lancet 69: 389-394 (Nov.) 1949.
Boies, L. R.: Headache and Neuralgia of Nasal Origin, Chicago M. Soc. Bull. 53:83-86 (Aug. 5) 1950.
Friedman, A. P.: Modern Headache Therapy, St. Louis, C. V. Mosby Company, 1951.
Hansel, F. K.: Penicillin Sensitivity, Ann. Allergy 7:619-624 (Sept.-Oct.) 1949.
Hilsinger, R. L.: Headache and Autonomic Imbalance, Laryngoscope 61:296-303 (April) 1951.
Hollender, A. R.: Nose, Throat and Ear, Chicago, The Year Book Publishers, Inc., 1950.
Horton, B. T.: The Use of Histamine in the Treatment of Specific Types of Headaches, J. A. M. A. 116:377-383 (Feb. 1) 1941; Symposium: Head and Face Pain; Medicine, Tr. Am. Acad. Ophth. 49:23-33 (Sept.-Oct.) 1944.
Lederer, F. L.: Diseases of the Ear, Nose and Throat, Philadelphia, F. A. Davis Company, 1942.
Lederer, F. L., and Hollender, A. R.: Textbook of the Ear, Nose, and Throat, ed. 3, Philadelphia, F. A. Davis Company, 1951.
Moench, L. G.: Headache, Chicago, The Year Book Publishers, Inc., 1947.
Williams, H. G.: Lecture, Florida Society of Ophthalmology and Otolaryngology, 1952.
Wolf, G. D.: Ear, Nose, and Throat: Symptoms—Diagnosis—Treatment, Philadelphia, J. B. Lippincott Company, 1948.
Wolff, H. G.: Headache and Other Head Pain, New York, Oxford University Press, 1948.

408 Blount Building.

Healed Dissecting Thoracic Aneurysm, Coexisting with Saccular Thoracic Aneurysm And Ruptured Abdominal Aneurysm: Report of Case

H. Milton Rogers, M.D.
ST. PETERSBURG

The case described is reported because of the unusual pathologic findings, a healed dissecting aneurysm and a nonsyphilitic thoracic aneurysm coexisting with an arteriosclerotic abdominal aneurysm. The diagnoses of saccular thoracic aneurysm, dissecting thoracic aneurysm and saccular abdominal aneurysm which were made clinically were confirmed at necropsy.

Report of Case

The patient was a white man 64 years of age. He was first examined by me on Oct. 21, 1947, when he presented himself for routine medical investigation. In July 1947, he had experienced an attack of substernal and epigastric pain which soon extended to the lower part of the abdomen. He was hospitalized for four weeks, during which period a diagnosis of multiple aneurysms of the descending aorta, associated with an arteriosclerotic aneurysm of the abdominal aorta, was made. There had been no preexisting thoracic pain. The past medical history was noncontributory. There had been no medical or surgical illnesses of note. The patient had practiced his profession of dentistry until his retirement two years before the onset of the present illness. No knowledge of previous hypertension had existed.

The physical examination revealed a well nourished white man. The pulse rate was 76 beats per minute. The blood pressure was 150 mm. of mercury systolic and 80 diastolic. The head and neck were normal. The pupils were round and equal and reacted normally to light and accommodation. The examination of the heart revealed that the aortic second sound was of greater intensity than the pulmonic second sound. There was an aortic systolic murmur, grade 2. No diastolic murmurs were heard. A large pulsating mass in the midabdomen was considered to be an aortic aneurysm. Pulsations in the arteries of the lower extremities were normal.

The following laboratory examinations were made: A blood cell count showed 3,760,000 erythrocytes per cubic millimeter, and the blood hemoglobin determination was 73 per cent, or 10.5 Gm. per hundred cubic centimeter of whole blood. The leukocytes numbered 7,300 per cubic millimeter of blood. Urinalysis gave normal results. The Kahn flocculation reaction for syphilis was negative. An electrocardiogram revealed sinus rhythm with 70 beats per minute. The P-R interval measured 0.16 second. Left axis deviation was present. The T waves were upright in leads I, II and CF4. Roentgenoscopic examination of the thorax gave evidence of expansile pulsations of the midportion of the descending aorta with aneurysmal dilatation. In addition, aneurysmal dilatation of the lower part of the descending thoracic aorta was observed, to the right of the shadow created by the right border of the heart.

Roentgenographic examination of the thorax (fig. 1) showed the lung fields to be clear. There was accentuation of the aortic knob. The descending thoracic aorta was characterized by an S-shaped tortuosity. Aneurysmal dilatation of the midportion of the descending aorta extending to the left and aneurysmal dilatation of the lower third of the descending thoracic aorta extending to the

right were present. Roentgenographic examination of the abdomen (fig. 2a) demonstrated a faint outline of laminated calcium plaques within the walls of the distended abdominal aorta. This calcified area extended from the first to the fifth lumbar vertebra. On lateral examination (fig. 2b) of the abdomen the aneurysmal dilatation of the aorta was more noticeable and measured 7.0 cm. in width.

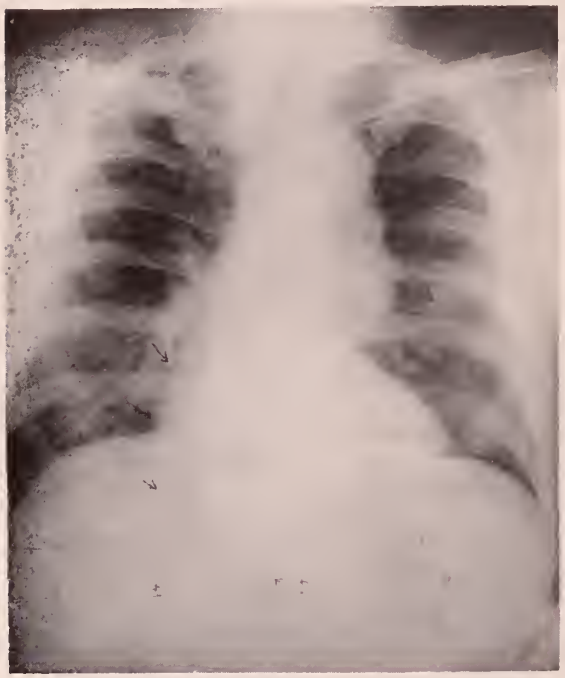


Fig. 1.— Roentgenogram of the thorax, Oct. 21, 1947. Aneurysms of the descending aorta.

The patient was under observation from October 1947 to July 1950. During this period there were no symptoms referable to the cardiovascular system. The results of physical examinations remained unchanged. In October 1948, Bell's palsy involving the left side of the face developed. Convalescence following this was uneventful.

The patient was last seen alive on July 1, 1950. For one month previously there had been some backache in the lower lumbar region, but this symptom had recently subsided. On the evening of July 11, sudden severe pain in the lower part of the abdomen developed. Death occurred five minutes later, before the patient could be attended by a physician.

At necropsy the pertinent findings were confined to the cardiovascular system. The heart weighed 350 Gm. The valves were normal. The coronary arteries gave evidence of arteriosclerosis, grade 3. The myocardium showed hypertrophy, the left ventricle measuring 23 mm. in thickness. There were focal areas of scarring, but no evidence of gross myocardial infarction was present.

There were three separate aneurysms of the aorta (fig. 3). Distal to the innominate artery the wall of the aorta showed aneurysmal dilatation with the superior portion protruding to the left of the vertebral column and the inferior portion of the aneurysm protruding to the right of the vertebral column. At this level the middle third of the esophagus was displaced laterally to the left.

The peritoneal cavity contained an estimated 1,500 cc. of free blood and recent blood clots. In the abdomen the aorta was covered with organized blood clots. There was a saccular aneurysm (fig. 4), measuring 11 cm. in length, extending from its point of origin 1 cm. below the orifice of the renal arteries to its termination at the bifurcation of the abdominal aorta. The aneurysm measured 7 cm. in its greater diameter. There was a longitudinal tear, which measured 2 cm. in length, on the anterior aspect of the abdominal aneurysm. Blood from the ruptured aneurysm had dissected into the retroperitoneal space and into the mesentery.

When the thoracic aorta was opened, the saccular aneurysm was found to originate at the junction of the descending aorta and the aortic arch (fig. 5a). The margins of this aneurysm were retracted. In the descending aorta there were three openings communicating with an intramural channel, which originated 5 cm. below the termination of the arch of the aorta (fig. 5b). The intramural channel was formed by two separate septums, one originating 5 cm. below the junction of the arch of the aorta with the descending aorta. This intramural channel and septum extended downward for a distance of 5.5 cm. to where the channel opened into the main lumen of the aorta. A second intramural channel began 1 cm. below the termination of the first channel. The septum forming the second intramural channel extended downward for a distance of 3 cm. The aortic surfaces of the septums, the intramural channel and the aortic lumen were covered by atheromatous plaques. The lesions described in the thoracic aorta were presumably the result of a healed dissecting aneurysm. The thoracic saccular aneurysm presumably was the result of the dissecting aneurysm, representing a portion of the aortic wall which had become interrupted with the edges retracted. That part of the aorta which had not ruptured became weak, and dilated to aneurysmal proportions. No evidence of syphilitic aortitis was present.

Extensive atheromatosis, ulceration and calcification of the entire abdominal aorta were present. The saccular abdominal aorta was presumably the result of arteriosclerosis.

Histologic examination of the thoracic aorta at the site of the saccular aneurysm revealed thinning of the wall of the media with absence of endothelial lining, presumably the result of the previous dissection below.

The histologic sections through the aortic wall and septums at the site of the dissecting aneurysm revealed a longitudinal splitting of the media. The septums forming the intramural channel were composed of poorly preserved media, and atheroma was present on both surfaces. On the aorta below the dissecting aneurysm were atheromatous plaques, calcific deposits and medionecrosis. There was adventitial thickening with diffuse and focal infiltration of lymphocytes. No perivascular lymphocytic infiltration was observed.

At the site of rupture of the abdominal aneurysm there were complete necrosis of the aortic wall, lymphocytic infiltration and extravasation of blood into the adventitia. Elastic tissue stains showed fragmentation and splitting of elastic fibers in all portions of the wall.

The anatomic diagnosis was ruptured arteriosclerotic aneurysm of the abdominal aorta, healed dissecting aneurysm of the thoracic aorta and pseudosaccular aneurysm of the aortic arch secondary to dissecting thoracic aneurysm.

Comment

The clinical manifestations of dissecting aneurysm and of arteriosclerotic abdominal aneurysm are well known. This case is reported because of unusual pathologic features consisting of three separate nonsyphilitic aneurysms coexisting in one patient. Clinical findings indicated and necropsy confirmed a saccular thoracic aortic aneurysm, a healed dissecting thoracic aneurysm and a saccular arteriosclerotic abdominal aneurysm. Death was the result of rupture of the abdominal aneurysm.

The occurrence of three separate nonsyphilitic aneurysms in one patient is noteworthy. Weiss[1]

recorded a syphilitic aneurysm of the thorax coexisting with a dissecting aneurysm. He emphasized that this association is not commonly encountered because syphilis of the aorta retards dissection of the aorta. Other cases of multiple aneurysms have been recorded infrequently. Kampmeier and White[2] reported coincident dissecting aneurysm of the thoracic aorta and ruptured saccular aneurysm of the abdominal aorta. Bauersfeld[3] recorded 1 case of syphilitic saccular aneurysm coexisting with a dissecting aneurysm. Butler[4] observed 1 case with a healed dissecting aneurysm and a subsequent acute aneurysm. Graybiel and Sprague[5] in 1941 reported a case of dissecting aortic aneurysm coexisting with a saccular thoracic aneurysm of nonsyphilitic origin. In the case reported here, the abdominal aneurysm was presumably the result of arteriosclerosis, while the dissecting aneurysm was probably the result of medionecrosis. The saccular thoracic aneurysm of nonsyphilitic origin was presumably due to a side effect of the dissecting thoracic aneurysm.

Fig. 2.—Roentgenograms of the abdomen, Oct. 21, 1947. Calcified abdominal aneurysm. a. Anteroposterior view. b. Lateral view.

Nonsyphilitic thoracic aneurysms, excluding dissecting lesions, are not common. They were first described by Korns,[6] and by Mills and Horton[7] in a clinical analysis of thoracic aneurysms observed at the Mayo Clinic, who stated that in their series 85 per cent were syphilitic and 15 per cent were probably nonsyphilitic or arteriosclerotic in origin. Ruffin, Castleman and White[8] in 1941 recorded 2 cases of nonsyphilitic thoracic aneurysm; in 1 of these cases there was a saccular aneurysm, and in the other case dilatation was superimposed on senile ectasia of the thoracic aorta. In a review of 66 cases of thoracic aneurysm observed at necropsy at the Massachusetts General Hospital, these authors noted that syphilis was the etiologic factor in 60 cases. In 3 of the remaining 6 cases nonsyphilitic saccular thoracic aneurysm was present, and in 3 diffuse dilatation classified as senile ectasia. In the case reported by Graybiel and Sprague[5] there was a saccular thoracic aneurysm of nonsyphilitic origin, presumably the result of a coexisting healed dissecting aneurysm.

Healed dissecting aneurysms of the aorta are being reported with increasing frequency.

Bostrom[9] emphasized the possibility of healing in dissecting aortic aneurysms. Crowell[10] stated that 20 per cent of patients with acute dissecting aneurysms have a chance to survive the initial episode. In Shennan's analysis of data on 300 dissecting aneurysms, there were 79 old healed dissecting aneurysms.[11] Weiss, Kinney and Maher[12] estimated that in 1 case in 10, dissecting aneurysms would heal spontaneously. Flaxman[13] reclassified healed dissecting aneurysms into two groups: old silent dissections, and old dissection showing recent active dissection, as in 4 of his cases. Levinson, Edmeades and Griffith,[14] in their series of 58 cases in which necropsy was performed, observed that healed dissections comprised 25.9 per cent of the total. Baer and Goldburgh[15] observed 2 cases of healed dissecting aneurysm in their series of 44 cases.

Fig. 3.— Thoracic and abdominal aorta, showing saccular thoracic aneurysm, healed dissecting aneurysm and ruptured abdominal aneurysm.

Gouley and Anderson[16] again directed attention to the ability of a chronic dissecting thoracic aneurysm to simulate aortic insufficiency of syphilitic origin. In the case reported here, the original episode of thoracic and upper abdominal pain was presumably on the basis of dissection of the aorta, which healed and then enabled the patient to survive for three years. No additional symptoms were present during this period that were referable to the multiple aneurysms. A diastolic murmur was not heard; the dissection did not occur in proximity to the aortic valve. In accordance with the hypothesis of Gouley and Anderson[16] for the mechanism of aortic murmurs associated with chronic dissecting aneurysms, the distance of the dissection from the aortic valve in this case explains the absence of aortic murmurs.

Fig. 4.— Arteriosclerotic abdominal aneurysm with site of rupture proximal to the iliac arteries.

Death occurred not as a result of cardiac failure, as is commonly observed in cases of chronic dissecting aneurysm, but as the result of rupture of a coexisting abdominal aneurysm.

Summary

A case is presented in which there was coexistence of three separate nonsyphilitic aortic aneurysms: a ruptured saccular abdominal aneurysm, a saccular thoracic aneurysm and a healed dissecting thoracic aneurysm. Death occurred as a result of recent rupture of the abdominal aneurysm.

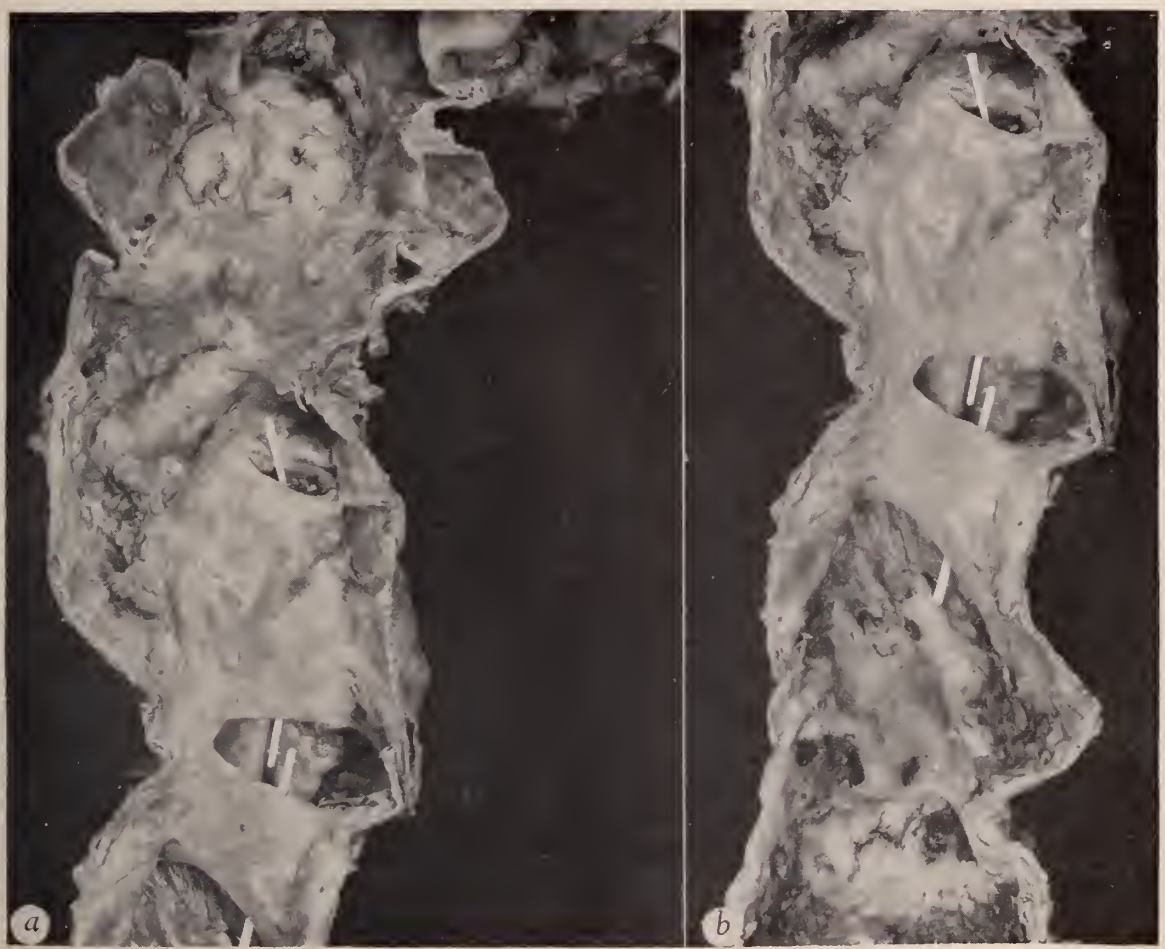


Fig. 5.—a. Thoracic aorta with saccular aneurysm and healed dissecting aneurysm. b. Healed dissecting aneurysm.

Abdominal aneurysms are being recognized clinically with increasing frequency. Arteriosclerosis is the major contributing cause in aneurysms that involve the abdominal aorta. In the series of Ruffin, Castleman and White[8] there were 20 aneurysms of the abdominal aorta. Of this number all but 3 were due to arteriosclerosis. Pratt-Thomas[17] was not in accord with the commonly advanced etiologic hypothesis of abdominal aneurysms, since he observed syphilis to be the etiologic factor in 15 of 17 aneurysms of the abdominal aorta. Epstein[18] reported on 9 cases of abdominal aneurysm; in 2 cases vascular syphilis contributed to the etiology.

References

1. Weiss, S.: Dissecting Aneurysm of Aorta; Two Cases With Unusual Features, New England J. Med. 218:512-517 (March 24) 1938.
2. Kampmeier, R. H., and White, J. W.: Coincident Dissecting Aneurysm of Thoracic Aorta and Saccular Aneurysm of Abdominal Aorta, Colorado Med. 30:299-300 (Aug.) 1933.
3. Bauersfeld, S. R.: Dissecting Aneurysm of Aorta; Presentation of Fifteen Cases and Review of Recent Literature, Ann. Int. Med. 26:873-889 (June) 1947.
4. Butler, S.: Dissecting Aortic Aneurysm; Unusual Case Having Previous Healed Dissection and Later Slow Dissection of all Major Aortic Branches, Am. J. Med. 3:643-651 (Nov.) 1947.
5. Graybiel, A., and Sprague, H. B.: Dissecting Aneurysm of Aorta; Case Report of Negro with Aortic Regurgitation and Saccular Aneurysm of Aorta of Nonsyphilitic Origin, Am. Heart J. 21:530-533 (April) 1941.

6. Korns, H. M.: Uber das atherosklerotische und Kombinationsaneurysma, Virchows Arch. f. path. Anat. 279:512-533, 1930.
7. Mills, J. H., and Horton, B. T.: Clinical Aspects of Aneurysm, Arch. Int. Med. 62:949-962 (Dec.) 1938.
8. Ruffin, M. deG.; Castleman, B., and White, P. D.: Arteriosclerotic Aneurysms and Senile Ectasia of Thoracic Aorta, Am. Heart J. 22:458-468 (Oct.) 1941.
9. Bostrom, A.: Quoted by Flaxman, N.[13]
10. Crowell, P. D.: Dissecting Aneurysms of Aorta, Report of Cases and Review of Literature, J. A. M. A. 77:2114-2117 (Dec. 31) 1921.
11. Shennan, T.: Dissecting Aneurysms Special Report, Medical Research Council, London, His Majesty's Stationery Office, 1939.
12. Weiss, S.; Kinney, T. D., and Maher, M. M.: Dissecting Aneurysm of Aorta With Experimental Atherosclerosis, Am. J. M. Sc. 200:192-203 (Aug.) 1940.
13. Flaxman, N.: Dissecting Aneurysm of Aorta, Am. Heart J. 24:654-664 (Nov.) 1942.
14. Levinson, D. C.; Edmeades, D. T., and Griffith, G. C.: Dissecting Aneurysm of Aorta; Its Clinical, Electrocardiographic and Laboratory Features; Report of 58 Autopsied Cases, Circulation 1:360-387 (March) 1950.
15. Baer, S., and Goldburgh, H. L.: Varied Clinical Syndromes Produced by Dissecting Aneurysm, Am. Heart J. 35:199-211 (Feb.) 1948.
16. Gouley, B. A., and Anderson, E.: Chronic Dissecting Aneurysm of Aorta, Simulating Syphilitic Cardiovascular Disease; Notes on Associated Aortic Murmurs, Ann. Int. Med. 14:978-990 (Dec.) 1940.
17. Pratt-Thomas, H. R.: Aneurysm of Abdominal Aorta; Analysis of 17 Cases, J. South Carolina M. A. 40:251-253 (Dec.) 1944.
18. Epstein, J.: Aneurysms of Abdominal Aorta, Ann. Int. Med. 22:252-270 (Feb.) 1945.

Box 632.

Diabetic Neuropathy

SIDNEY DAVIDSON, M.D.
LAKE WORTH

The occurrence of a characteristic neurologic disorder associated with diabetes mellitus has been known for many years. Calvi[1] in 1864 and Bouchard[2] in 1885 recognized the existence of neurologic lesions which involved the peripheral nerves and which were associated with diabetes mellitus. In 1885, Althus,[3] in his description of the clinical picture of this disease, noted its great similarity to tabes dorsalis. Two years later, Pryce[4] reported 3 cases of diabetic neuropathy which he labeled as pseudotabes. He was able to correlate the clinical picture with specific pathologic alterations.

The existence of diabetic neuropathy, therefore, has been recognized and fully described for more than 50 years. Nevertheless, despite the enormous advances in knowledge concerning the fundamental problems involved in diabetes itself, the mechanisms responsible for the production of diabetic neuropathy have not been clarified and its etiology is still a subject of considerable disagreement. This confusion is due in great part to disorders which so often and so characteristically complicate diabetes. The most common and most important of these is peripheral vascular disease. Peripheral arterial disease may of its own accord initiate neuritic symptoms, or it may augment and complicate a neuritis of a different etiology. Another confusing complication may be the poor nutrition and vitamin deficiency observed in cases in which the diabetes is poorly controlled. These complications have made the evaluation of the etiologic factors in diabetic neuropathy difficult.

Etiology

The arteriosclerosis of diabetes, with the resultant impaired blood supply to the extremities and to the nervous system, has been frequently regarded as the important etiologic agent in the production of diabetic neuropathy. Woltman and Wilder,[5] Dolger[6] and others have thought that diabetic neuropathy is primarily a result of a vascular lesion. Dolger[6] suggested that diabetic neuropathy represents a sensitive indicator of vascular damage, and postulated that minute vascular lesions in significant areas are responsible for the protean symptoms. Involvement of the nutrient vessels and of the vasa vasorum may occur in both the central and peripheral portions of the nervous system and may, therefore, result in a varied and confusing symptomatology. Since the lesions are fundamentally vascular, this author believed that the lesion is to be considered irreversible and did not expect improvement with the use of vitamin preparations or with more rigid control of the diabetes. Rundles[7] and Joslin and others[8] did not agree and suggested that the clinical facts cannot be reconciled to this viewpoint. They noted that the acute onset, the involvement of visceral neurons, and the definite clinical recoveries are not in accord with such a view. In a complete review, Rundles[7] stated that, although certain changes are common to both vascular disease and diabetic neuropathy, there is little evidence to support the contention that vascular factors are important in the etiology of diabetic neuropathy.

It has been suggested by many competent observers that a vitamin deficiency is the etiologic agent in the development of diabetic neuropathy. It has been held by some[9,10] that diabetic diets in general are deficient in vitamin B content. Other careful studies,[8,11,12] however, have demonstrated that the modern diabetic diet is more than adequate in vitamin B complex content. Other mechanisms for the production of such a deficiency have been advanced. It has been suggested that defective absorption, loss of water-soluble vitamins in polyuria, or increased metabolic need might result in a relative deficiency. The presence of such a relative or conditioned deficiency has not been confirmed by balance studies or animal experimentation.[11] Clinically, a high incidence of vitamin B deficiency has been reported by some,[13] while others have found little evidence of such a deficiency in their patients.

Studies by Rundles,[7] Joslin and his associates[8] and others[14] on the detailed diabetic background of patients with diabetic neuropathy agree that most of these patients have histories characterized by neglect, poor treatment and prolonged persistent hyperglycemia. A history of ketosis is not always present. It is this lack of diabetic control which is in some way the most probable etiologic agent in diabetic neuropathy. Although the diabetic control is poor, there is no correlation between the severity of the diabetes or any of the acute complications such as coma or acidosis and the incidence of diabetic neuropathy. Those incidents which may aggravate the diabetes, however, such as infections and lapses in therapy, may cause aggravation of the neuritic symptoms which will parallel the course of the diabetes. In general, the more severe and the more prolonged the neglect of the diabetes, the more intense is the neuropathy.

Anatomically, almost any part of the nervous system may be involved, although clinically the most commonly recognized lesions are those of the peripheral nerves. The nervous system unit most commonly involved is the poorly myelinated small caliber neuron.[15] This type of neuron is responsible for the mediation of pain and thermal sensibility. It also mediates autonomic functions. Rundles[15] compared this lesion with the one in pernicious anemia; in the latter case, the large heavily myelinated neurons which conduct motion, position sense and vibratory sensibility are the first affected. Pain is rarely a significant complaint in pernicious anemia, while it is extremely common in diabetic neuropathy. In pernicious anemia, exaggeration of the tendon reflexes, clonus and spasticity resulting from a lesion in the posterior and lateral columns are common, but no such lesion is found in diabetic neuropathy. The cerebral symptoms, which often are so refractory to treatment in pernicious anemia long after the hemogram has returned to normal, are not present in diabetic neuropathy. Cerebral symptoms occur infrequently in diabetes, but when present are usually a result of a vascular lesion rather than a result of a primary lesion of the central nervous system.

The nature of the biochemical lesion responsible for the neuropathy is unknown. It is recognized that it occurs almost always with uncontrolled diabetes, and is therefore associated with an insulin deficiency. It is not known in what manner this deficiency leads to the neuropathy. In the neuritis of thiamine deficiency, it is known that the metabolism of carbohydrates cannot go beyond the pyruvic acid stage because of the lack of an enzyme of which thiamine is an important constituent. Not so much is known about insulin deficiency, but it is known that in such a deficiency, the metabolism of carbohydrates is stopped at the 6-carbon stage, probably at the stage of phosphorylation of glucose. It is not known exactly what role insulin plays in this phosphorylation, nor indeed why such a defect should result in a neuritis. It is possible that the lesion may lie in a defect in fat metabolism. Under ordinary circumstances, fat is broken down in the liver to ketone bodies, which are then utilized at the periphery. When the diabetic patient cannot utilize his carbohydrate intake owing to a deficiency of insulin, the catabolism of fat is increased. When this catabolism exceeds 150 Gm. a day, ketonuria appears and diabetic acidosis results.[16] Although the metabolism of the nervous system primarily utilizes carbohydrates, the large lipid content of nervous tissue makes it probable that excessive fat metabolism may affect the structure of the nervous tissue. It is important to remember in this connection that the vascular lesion in diabetes is often atherosclerotic, although this is not always the case. It may be, therefore, that the alteration in fat metabolism is not merely the overproduction of ketone bodies in an acceleration of a normal process, but that other unknown alterations in fat metabolism may be the key to the production of diabetic neuropathy, as well as to other diabetic complications.

Symptoms

The symptomatology may be most varied. Muscular cramps, aching, and weakness of the legs are frequent early symptoms. Numbness, tingling, and paresthesias are common complaints. Also, there is a feeling of aching and burning, and a sensation of "cold." A characteristic complaint is that of severe deep shooting pains. These pains are common, and they frequently so overshadow the classical symptoms of uncontrolled diabetes that it is this complaint which leads the patient to the physician and thence to the discovery of the diabetes. The lower extremities are involved more often and more severely than are the upper. Occasionally, the pudendal, femoral or intercostal nerves may be involved.

The most common and constant sign is that of diminished or absent tendon reflexes in the lower extremities. The next most common signs are hyperesthesia or dysesthesia of the involved extremity; loss of hot and cold sensibility is most common. Pronounced muscle tenderness may be elicited. There is usually diminished vibratory sense, but position sense is not commonly affected. There is no evidence of involvement of the lateral or posteriod columns.

Complaints referable to other systems besides the peripheral nervous system are common. Unusual and sometimes serious gastrointestinal symptoms may develop as a result of diabetic neuropathy. Studies by Hodges, Rundle and Hanelin[17] revealed that symptoms referable to the lower portion of the gastrointestinal tract appear first. The most common symptom is a severe intractable constipation. Chronic diarrhea may appear and may alternate with the constipation. The diarrhea is sometimes nocturnal, and may be severe.

Symptoms of disturbances of the upper part of the gastrointestinal tract are usually associated with other evidences of severe diabetic neuropathy. These are commonly cramps in the upper abdominal region and postprandial distention. Despite the severity of the symptoms, the roentgen findings are remarkably meager.[17] Some evidence of disturbed function, such as puddling, delay, and dilatation of the loops of the small bowel can be seen, but in general the findings cannot be correlated with the clinical symptoms. The basis of these symptoms is undoubtedly involvement of the autonomic nervous system, and although the clinical disturbances of this disorder are severe and generally intractable, they do respond to therapy.

Genitourinary disturbances are also common. Difficulty in urination, acute retention of urine, or impotence in the male may be the complaints. Cystometric studies have revealed that atony of the bladder is the cause of many of these complaints.[7]

Peripheral autonomic nerve lesions as well as the visceral ones also occur. Sweating deficiencies and loss of vasomotor control are not uncommon. Alteration in the nutrition of the skin occurs and may lead to ulceration in the extremity. Orthostatic hypotension and orthostatic tachycardia have been described and may be severe.[7]

Treatment

Although some authors[13,18] have emphasized the utilization of the vitamin preparations in the treatment of this condition, proof of their efficacy is not convincing, since such treatment usually coincides with the more vigorous and more controlled treatment of the diabetes. The only logical treatment as yet seems to be control of the diabetes. The underlying cause is an insulin deficiency, and the treatment must be correction of that deficiency. This lies in good diabetic management, which implies an adequate diet with sufficient insulin to result in little or no glycosuria, with as close as possible to normal fasting blood sugars.

The prognosis is generally good, although it may vary depending on the extent of the neuritis, its severity and length of duration. The shorter the duration, the more readily reversible is the lesion; whereas, if it is too prolonged, the lesion may become irreversible and may not respond to the best of management.

To illustrate some of the problems outlined, the following 6 cases are presented:

Report of Cases

Case 1. — Mrs. A. K., a white woman aged 72, was first seen on March 1, 1949. She had been a known diabetic for 15 years and had not seen a physician for 5 years. She had no complaints, but came in for a physical examination, which revealed some sclerosis of the retinal vessels but no other significant abnormalities except on neurologic examination. There was no evidence of any circulatory deficiency of the lower extremities. The pulses were good; the temperature and the color were normal. On neurologic examination, no ankle or knee jerks could be elicited. There was great diminution in perception to pinprick, to light stroking, and to heat and cold in a stocking distribution. Vibratory perception was somewhat diminished, but position sense was unaltered. Urinalysis showed 4 plus sugar, but no acetone. The blood sugar was 256 mg. per hundred cubic centimeters. The carbohydrate intake was diminished, and the diabetes was controlled with insulin. For the next two years the disease

was under fair control, the patient taking 25 units of protamine zinc insulin daily. She rarely had glycosuria, and the fasting blood sugars were usually under 150 mg. An examination on May 2, 1951 revealed no great change in the neurologic condition; there was still no evidence of circulatory insufficiency.

This case demonstrates diabetic neuropathy resulting after prolonged diabetic neglect. It was apparently confined to the peripheral nervous system. There was no evidence of a relationship to vascular deficiency. Under fairly good diabetic control, the lesion appeared to be irreversible. There is still a possibility, however, that further good control of the diabetes may result in reversal of the lesion.

Case 2. — R. W. J., a white man aged 68, was known to have had diabetes for 33 years. He had had a coronary occlusion in 1947. The diabetes had always been severe, for he required, when first seen, 56 units of a 2 to 1 mixture. He was an intelligent patient, and his records showed that the disease had always been under fairly good control. In December 1950, at the time of his first visit to me, his complaints were referable to the cardiovascular system. There was a moderately severe anginal syndrome, and he complained of severe intermittent claudication, restricting his walking to half a block at a time. Examination revealed clinical and electrocardiographic evidence of moderately severe arteriosclerotic hypertensive heart disease. There was poor circulation of the lower extremities; the color was poor, with blanching on elevation and rubor on dependence. The femoral pulses were palpable bilaterally, but the popliteal, posterior tibial and dorsalis pedis vessels could not be felt. There was decided coolness bilaterally below the midleg. Neurologic examination revealed diminished deep reflexes bilaterally, but no sensory disturbances could be elicited. There was some diminution in vibratory sense, but position sense was normal.

This case demonstrates severe vascular disturbance involving the heart and peripheral arterial system, so characteristic of long-standing diabetes. Despite the length and severity of the diabetes, however, and the extent of the vascular lesion, the evidence of the neuritis was minimal. This was probably a result of comparatively good control of the diabetes, although this control could not prevent the appearance of the vascular lesions.

Case 3. — V. W., a white man aged 58, first consulted me in May 1951. His chief complaint was that of severe intermittent agonizing pain in both lower extremities. The pain was localized in the thigh region, had no definite distribution, but was most disabling. It was much worse at night, and kept him from sleeping. He also complained of great weakness of both lower extremities, which prevented his walking more than one block at a time. There was no intermittent claudication. He complained of dizziness, which was worse on change in position, especially on sitting or standing after lying down. There was a loss in weight of about 20 pounds in six months. On being questioned, he admitted to some polyuria but no polydipsia. He had been told some five years before that he had diabetes, but had never made any serious attempt to control it, and, when seen, had not taken any insulin or observed a diet for at least a year.

Physical examination revealed 2 plus sclerosis of the retinal vessels. The blood pressure was normal, and the heart seemed to be normal. The liver was two fingers down, smooth and nontender. The color of the extremities was fair, with somewhat more than normal blanching on elevation and some rubor on dependence. The femoral and popliteal pulse could be felt on both sides, but the posterior tibial and dorsalis pedis arteries were not palpable. Neurologic examination revealed loss of all deep reflexes in the lower extremities, spotty areas of hyperesthesia on the anterior aspect of the thigh, and almost complete loss of sensation to pinprick, touch, and heat and cold in a stocking distribution, beginning at the level of the midcalf. Position sense was poor; vibratory sense was almost gone. The blood pressure was 110 systolic and 80 diastolic at rest; on sudden standing, it dropped to 90 systolic and 60 diastolic, and the patient complained of faintness and dizziness. Urinalysis showed a 4 plus sugar, with no acetone; the blood sugar was 256 mg.

The patient was given a free diet, and then insulin therapy was started. The pain in the thighs rapidly diminished; tolerance for walking became greater and the legs stronger; the dizziness vanished. When seen on July 10, 1951, the disease was under fair control, and he was taking 32 units of insulin; the postural hypertension could no longer be demonstrated. There were slight but positive evidences of deep reflexes, the areas of hyperesthesia in the thighs had vanished, and the hypesthesia in the legs was diminished but was still present. The signs of peripheral arterial insufficiency were unchanged.

This case demonstrates how the pain of severe diabetic neuritis may bring the diabetic patient to the physician. Besides the evidence of peripheral neuropathy, there was also postural hypotension. The decided and rapid response of some of the lesions to therapy, with the persistence of the vascular lesions, should be noted.

Case 4. — H. P., a white man aged 62, had a coronary occlusion in 1948, at which time it was discovered that he had mild diabetes. In May 1951, he had a cerebral thrombosis. The diabetes was mild and was readily controlled by means of a free diet and 15 units of protamine insulin. Physical examination revealed a 3 plus sclerosis of the retinal vessels. He was normotensive. The peripheral circulation was poor; the color of the legs was poor, with decided blanching on elevation and rubor on dependency; pulsations in the dorsalis pedis and posterior tibial arteries were absent bilaterally. There was appreciable temperature change just above the ankle. Neurologic examination revealed no residue of the cerebral accident, except for an aphasia. The deep reflexes in the lower extremities were equal and active; there were no sensory changes; vibratory sense and position sense were normal.

This case illustrates severe vascular disease in a patient with comparatively mild, well controlled diabetes. There were, however, no evidences of diabetic neuropathy.

Case 5. — Mrs. E. M., a white woman aged 43, when first examined in January 1951 complained of loss of weight, polyuria, polydipsia, and vaginal itching of four months' duration. There was no previous history of diabetes. Physical examination revealed a severe vaginitis. There was no evidence of peripheral vascular disease. Neurologic examination revealed markedly diminished deep reflexes in the lower extremities bilaterally, great hypesthesia to pinprick, to touch, and to heat and cold. There was no alteration in position or vibratory sense. There was a 4 plus urine sugar, and the blood sugar was 356 mg. The disease was controlled readily on a free diet and on insulin. When the patient was last seen on April 27, 1951, the deep reflexes were normal and the sensory abnormalities were no longer present.

This case represents the acute neuritis resulting from uncontrolled diabetes of comparatively short duration, which is readily and totally re-

versible, probably because of the short duration of the disease.

Case 6. — Mrs. B. J., a white woman aged 66, was first examined on April 12, 1951. The chief complaint was loss of control of the urine of three days' duration. There were no other complaints; there was no previous history of diabetes. Urinalysis showed a 4 plus sugar, with no acetone, pus or albumen; the blood sugar was 257 mg. There was no evidence of vascular disease, but there was great diminution in the deep reflexes of the lower extremities, and a definite hypesthesia in a stocking distribution. No alteration in position or vibratory sense could be elicited. The disease was easily controlled on diet alone, and by May 18 the fasting blood sugar was 154 mg. and glycosuria was no longer present. She had regained normal control of the bladder, the hypesthesia had vanished, and the deep reflexes in the lower extremities were normal.

This case demonstrates both visceral and peripheral involvement. It also demonstrates that when the lesion is not long-standing, approximation of diabetic control will readily result in a reversal of the lesion. It is noteworthy here that the neurologic lesion led to the discovery of the diabetes.

Discussion

In reviewing these cases, one is struck by the readiness with which more recent lesions resolve and the stubbornness of those lesions which have lasted for some time. Based on the duration and the refractoriness to therapy of the lesions of diabetic neuropathy, a distinction in classification has been made,[7] and it has been suggested that the pathologic physiology of the more recent lesions differs from that of the longer lasting lesions. Rundles[7] suggested that the term diabetic neuritis should not be applied to those lesions which are cleared up readily by control of the diabetes. I, however, see no reason for this distinction. This type of neuropathy is a result of uncontrolled diabetes. If the uncontrolled phase has existed too long, the lesion may become irreversible, as in case 1. Hope should never be lost, however, since recovery has been known to occur years after therapy was begun.[8] It is not known as yet whether more rigid control and close approximation to normal chemistry will lead to quicker recovery of the patient. I believe, however, that in diabetic neuropathy the best possible control should be attempted.

Diabetic neuropathy is one of the early complications that causes pain. For this reason, it frequently leads to the discovery of the diabetes. In cases 3 and 6, the uncomfortable neuropathy led to the discovery of the uncontrolled diabetic state. Uncontrolled diabetes often does not cause enough discomfort, and may go on for some time in the careless or unheeding patient without leading to adequate medical attention. Diabetic neuritis is the one complication that really hurts.

Summary

A brief discussion of diabetic neuritis is presented, and 6 cases are reported. The relationship of the extent of the lesion to the severity and duration of the uncontrolled phase of the diabetes is discussed. The role of pain of diabetic neuropathy in the discovery of diabetes is mentioned.

References

1. Marchal de Calvi: Recherches sur les Accidents Diabetiques, Paris, P. Asselin, 1864.
2. Bouchard, C. H.: Sur la Perte des Reflexes Tendineux dans le Diabete Sucre, Progr. méd., Paris 12:819, 1884.
3. Althus, J.: On Sclerosis of the Spinal Cord, New York, Putnam, 1885.
4. Pryce, T. D.: On Diabetic Neuritis, with a Clinical and Pathological Description of Three Cases of Diabetic Pseudotabes, Brain 16:416, 1893.
5. Woltman, H. W., and Wilder, R. M.: Diabetes Mellitus; Pathologic Changes in Spinal Cord and Peripheral Nerves, Arch. Int. Med. 44:576-603 (Oct.) 1929.
6. Dolger, H.: Vascular Complications of Diabetes Mellitus, Bull. New York Acad. Med. 26:779-785 (Dec.) 1950.
7. Rundles, R. W.: Diabetic Neuropathy, General Review with Report of 125 Cases, Medicine 24:111-160 (May) 1945.
8. Joslin, E. P., and others: The Treatment of Diabetes Mellitus, ed. 8, Philadelphia, Lea & Febiger, 1946.
9. Joliffe, N.: Handbook of Nutrition; Conditioned Malnutrition, J. A. M. A. 122:299-306 (May 29) 1943.
10. Williams, R. R., and Spies, T. D.: Vitamin B_1 (Thiamin) and Its Use in Medicine, New York, The Macmillan Company, 1938.
11. Owens, L. B.; Rockwern, S. S., and Brown, E. G.: Evaluation of Vitamin B. Therapy for Diabetes, Arch. Int. Med. 66:679-687 (Sept.) 1940.
12. Needles, W.: Vitamin Studies in Cases of Diabetic Neuritis, Arch. Neurol. & Psychiat. 41:1222-1228 (June) 1939.
13. Rudy, A.: Diabetic Neuropathy, New England J. Med. 233:684-689 (Dec. 6) 1945.
14. Wendt, L. F. C., and Peck, F. B.: Diabetes Mellitus; Review of 1073 Cases, 1919-1929, Am. J. M. Sc. 181:52-65 (Jan.) 1931.
15. Rundles, R. W.: Diabetic Neuropathy, Bull. New York Acad. Med. 26:598-616 (Sept.) 1950.
16. Stadie, W. C.: Intermediary Metabolism in Diabetes Mellitus, Harvey lecture, January 15, 1942, Bull. New York Acad. Med. 19:778-810 (Nov.) 1943.
17. Hodges, F. J.; Rundles, R. W., and Hanelin, J.: Roentgenologic Study of Small Intestine; Dysfunction Associated with Neurologic Disease, Radiology 49:659-673 (Dec.) 1947.
18. Collens, W. S., and others: Treatment of Peripheral Neuropathy in Diabetes Mellitus, Am. J. M. Sc. 219:482-487 (May) 1950.

8 South J Street.

Seventy-Ninth Annual Convention
Florida Medical Association
Hollywood, April 26-29, 1953

The Use of the Antihistamines as Local Anesthetic Agents

F. James Stubbart, M.D.
ORLANDO

The local anesthetic property of the antihistamines was known as early as 1939.[1] Since that time, numerous papers have been written, both experimental and clinical, declaring their advantages over the more commonly used drugs. Yet they have achieved little popularity as anesthetics except as antipruritics in various dermatologic disorders. The antihistamines have been shown to be satisfactory agents for nearly all types of conduction anesthesia. Not only are they more potent and longer acting in many instances, but they almost entirely lack the undesirable side effects of the conventional agents.[2]

Action and Side Effects

The antihistamines in general have a bitter taste and cause a burning sensation when applied to the oral and nasal mucous membranes. This effect, however, quickly disappears with the onset of the anesthesia.[3] Despite this apparently irritating quality, 1 per cent solutions have been repeatedly instilled in the eye with no pain, hyperemia or pupillary changes. The therapeutic ratio of these drugs is high. The MLD 50 (oral) of pyribenzamine is between 210 and 570 mg. per kilogram. Yet the quantity estimated to be absorbed in the process of anesthetizing for gastroscopy is estimated to be not over 4 mg. per kilogram.[4] The symptoms of overdosage, namely excitation, convulsions or depression, suggest that the antihistamines have some toxic features in common with pontocaine, cocaine and related drugs.

Potency

Dews and Graham[5] found neoantergen to be three times as strong as cocaine, and the anesthesia persists longer.[6] Landau, Nelson and Gay[7] compared the efficacy of 0.05 per cent solutions of procaine and various antihistamines in producing local anesthesia in an intradermal wheal. They found dramamine, benadryl and pyribenzamine to be about 2.2 times and phenergan and antistine about 5.2 times as effective as procaine. I have found 1 per cent solutions to be effective in relieving the pain of hemorrhoids after almost complete failure by recognized ointments, and also in acute otitis externa when even cocaine has proved ineffective.

The anesthetic potency of these drugs has been shown to have no direct relation to their antihistaminic potency. In fact, these properties probably have more nearly an inverse ratio.[8] It is also probable that their potency when used topically, by injection, or orally, may not be directly related.[7]

Onset and Duration

The method and site of application have considerable influence on the time of onset and the duration of anesthesia. A swab of 1 per cent pyribenzamine applied for 10 seconds to the lip and tongue produces loss of taste in 30 to 40 seconds, numbness in two and one-half minutes and anesthesia to pin prick in four minutes.[3] A period of 10 to 15 minutes is adequate for the passage of the gastroscope or for corneal anesthesia. Applied by swab for 10 seconds to the tongue, this drug induces anesthesia which may be expected to last for about 10 to 15 minutes and as applied in gastroscopy for 40 to 90 minutes. Pyribenzamine 2 per cent in water-soluble ointment base applied to hemorrhoids lasts from one and one-half to two hours. More prolonged anesthesia may be attained by repeatedly wetting cotton wicks or pledgets in place about every 45 to 60 minutes. One factor probably concerned in prolonging the effect is the ability of the antihistamine to produce inhibition in the hyaluronidase test.[9]

Application

Relief from the pain associated with eczema, pruritus ani and certain other skin conditions may be obtained with the antihistamine in water-soluble base. For cleansing, however, and debriding encrusted areas, 2 per cent aqueous solution is preferable.

Dental Use. — The pain experienced after dental extractions and, in some instances, owing to carious teeth can be alleviated by placing a

From the Orange Memorial Hospital, Orlando.

small amount of the powdered or crystalline drug in the cavity.

Cornea. — Anesthesia of the cornea has been achieved with 0.5 or 1.0 per cent solutions by applying 3 drops at three minute intervals for 10 to 15 minutes with no attending pain, hyperemia or pupillary changes.[6]

Otitis Externa. — By filling the external auditory canal with 1 or 2 per cent solution, sufficient anesthesia is achieved in 15 minutes in most cases to permit cleansing and examination. Prolonged relief has been obtained by repeatedly moistening a wick with this solution.

Gastroscopy. — Moseley[3] reported on several gastroscopies performed satisfactorily with this type of anesthesia. His patients were instructed to agitate 10 cc. of a 1 per cent solution in the mouth and then gargle repeatedly with it, the solution being retained in the mouth and pharynx for three minutes. The patient was then permitted to expectorate the solution, rest four or five minutes, and then repeat. In another method reported on the basis of a series of 42 cases,[4] routine procedures were to give conventional premedication; then a 1 per cent solution of pyribenzamine, or benadryl, was applied to the oropharynx in the same manner as pontocaine. The oral and buccal mucous membranes were swabbed with the solution being tested. The same solution was then applied to the pharynx, in the pyriform fossae, and in the esophagus through the esophageal catheter. Some of the patients, who previously had been subjected to gastroscopy with pontocaine anesthesia, found the results to be equally satisfactory. Only one failure was recorded in this series. In this case, pontocaine also failed to induce anesthesia, and an attempt at spinal anesthesia, undertaken previously, is said to have failed.

Transnasal Catheters. — I have also observed that the anesthesia afforded by these drugs aids in passing gastric tubes in apprehensive patients or those with a hyperactive gag reflex. The discomfort of the prolonged use of these tubes can be greatly relieved by regular applications of a 0.5 per cent or 1 per cent or 2 per cent solution with an atomizer. Slight burning was noted at the beginning of the initial application, but when the atomizer was left at the bedside the patients continued to use it.

Sore Throat. — Patients unable to eat because of the pain and discomfort of tonsillitis, stomatitis and tonsillectomy have been able to eat with relative ease 10 to 15 minutes after gargling with 10 cc. of 2 per cent solution for from two to three minutes. Also a temporary reduction in the size of swollen tonsils was observed in two patients. This was thought to be in part due to the local adrenergic potentiation effect of the anesthetic. One peritonsillar abscess was incised without pain after topical application of a 2 per cent solution.

Proctology. — Painful hemorrhoids may be relieved for 90 to 120 minute periods after application of 2 per cent antihistamine in a water-soluble ointment base. More prolonged anesthesia may be obtained by wetting a cotton or gauze wick with a 1 per cent or 2 per cent solution. This has been effective in cases in which the local application of conventional anesthetic agents has failed. Ten cubic centimeters of the solution may be painlessly injected into the anal canal with a rubber bulb syringe. The cotton wick method has been used with complete satisfaction in the postoperative period in cases of hemorrhoidectomy.

Sterile 0.5 per cent to 1.0 per cent solutions provide adequate anesthesia when injected in a routine infiltration technic to permit minor surgery. No undesirable side effects were observed.

The use of the antihistamines in premedication apparently is satisfactory. Their use to produce general intravenous anesthesia, however, has been accompanied by respiratory difficulty.

Summary

On the basis of clinical experience and a review of the literature, an attempt is made to illustrate the uses and advantages of the antihistaminic compounds as local anesthetic agents.

References

1. Staub, A. M.: Recherches sur quelques bases synthétiques Antagonistes de L'histamine, Ann. Inst. Pasteur 63:400-436 (Oct.) 1939.
2. Thomas, J. W., and Fenton, M. M.: Fatalities and Constitutional Reactions Following Use of Pontocaine, J. Allergy 14:145-159 (Jan.) 1943.
3. Moseley, V.: Use of Tripelennamine Hydrochloride (Pyrihenzamine) as Topical Anesthetic, Am. J. Digest. Dis. 15:410-411 (Dec.) 1948.
4. Reynolds, J.; Kahn, A. G., Jr., and Levy, J. S.: Use of Anti-histaminic Drugs for Local Anesthesia for Gastroscopy, Gastroenterology 14:535-537 (April) 1950.
5. Dews, P. B., and Graham, J. D. P.: Antihistamine Substance 2786 R.P., Brit. J. Pharmacol. 1:278-286 (Dec.) 1946.
6. Yonkmann, F. F., and others: Local Anesthetic Properties of Antistine and Pyribenzamine Hydrochloride, Anesth. & Analg. 28:170-173 (May-June) 1949.
7. Landau, S. W.; Nelson, W. A., and Gay, L. N.: Antihistaminic Properties of Local Anesthetics and Anesthetic Properties of Antihistaminic Compounds, J. Allergy 22:19-30 (Jan.) 1951.
8. Keating, J. U., and Code, C. F.: The Anesthetic and Antihistaminic Action of a Series of Antihistaminic Drugs in Human Skin, J. Lab. & Clin. Med. 33:1609 (Dec.) 1948.
9. Ford, R. T., and others: Comparison of Pharmacological Activities of Several Antihistiminic Agents, Federation Proc. 8:48-49 (March) 1949.
10. Annotations: Anti-Histamine Drugs in Anaesthesia, Lancet 2:214 (Aug. 4) 1951.

University of Michigan Hospital, Ann Arbor.

A Study of Medical Indigence Based Upon the State Cancer and Diabetes Control Program

Lorenzo L. Parks, M.D.
JACKSONVILLE

As the title of this presentation indicates, this paper is not an attempt to determine or define what a medically indigent case is, but to report on the findings in a study of 100 cases in which the patients have received financial assistance under the Cancer Control Program of the Florida State Board of Health.

In the discussion of the paper Dr. Smith will present a preliminary report only of a study made on the Diabetes Control Program whereby patients are supplied with insulin, if the patients are indigent. The word indigent, according to our dictionary, means "needy" or "destitute."

In 1944 at the session of the House of Delegates of the Florida Medical Association, the following legislation was recommended by its Committee on Cancer Control, and was adopted by the House of Delegates that year: "This committee believes that the cancer control situation in the State of Florida can best be promoted by state legislation which sets aside a definite sum each year for the establishment of cancer clinics for the indigent."

In 1947 the legislature provided funds and passed an act to promote the prevention and cure of cancer. This act outlined the following requirements:

1. "To authorize the Florida State Board of Health to establish a standard for the organization, equipment, and conduct of cancer units or departments in hospitals or in clinics of the State."

2. "To conduct an educational campaign for the control of cancer."

3. "To provide a plan for the care and treatment of indigent persons suffering from cancer."

Prior to the enactment of this law in 1947, a service had been provided whereby the pathologists of the state examined specimens of tissue submitted by physicians; if the patient was indigent, the State Board of Health paid the pathologist a small fee. This service was provided by a grant of $15,000 through the State Board of Health from the United States Public Health Service.

Administrative Problems

Properly speaking, we would say that our cancer program began in July 1947, and one of our first problems was to set up a system of determining how to select the patients that needed aid from those who could pay their own way. I should like to say here that the former Director of the Bureau of Preventable Diseases, Dr. R. F. Sondag, set up the system at that time, and basically we are continuing to use the same system that Dr. Sondag started in 1947.

On Sept. 20, 1947, the State Board of Health adopted rules and regulations pertaining to the determining of indigent patients, which read as follows: "Aid is limited to medically indigent persons. The responsibility for determining indigence rests with the county health officer, but he is expected to get the assistance of the attending physician and consultants on the case, his professional advisory committee and/or the local welfare agency in making such certifications. In other words, the resources for determining indigence vary so greatly within the state that we leave this matter entirely to local officials to work out. In accordance with the overall policy of the State Board of Health we are prepared to approve any method of determining indigence which a local medical society may recommend to the county health officer."

In carrying out the policies of the State Board of Health an application form was adopted. This application requires the signature of the attending physician, it gives the name of the patient, sex, color, address, type of malignancy, site, and general prognosis. The application form first adopt-

Director, Bureau of Preventable Diseases, Florida State Board of Health.

Read before the Florida Health Officers' Society, Seventh Annual Meeting, Hollywood, April 27, 1952.

ed required on the back of the application a simple statement signed by the health officer, or the welfare agency, that in the opinion of the signer the patient was indigent.

There have been a few changes in the initial application for state aid since the original one was adopted.

About four years ago the application form now in use was adopted. This form requires a statement to be signed by the patient stating his income, the value of the real estate he owns, if any, a statement as to unpaid debts, fixed family expenses, the amount of life insurance carried, and hospital insurance, if any. It also requires a statement as to whether a member of the family, or relative, could pay part of the expenses, and the regular certification signed by the health officer or welfare agency, more or less verifying the statement of the patient.

Complaints were received by us from one or two tumor clinic directors that patients were being approved for state aid who, in their opinion, were able to pay their own bills. It was decided to take this matter up with the Florida Cancer Council, and on May 3, 1951, the following instructions were sent to all county health directors and tumor clinic directors: "At a recent meeting of Florida Cancer Council it was recommended by this group, and later approved by the State Board of Health, that the staff at the tumor clinics may disapprove of state aid for a case, if in their opinion or after investigation that they may wish to make, they find that the patient is financially able to pay for the treatment. The county health director is still responsible for approving or disapproving the case for state aid, and the tumor clinic staff acts as a second screening aid."

I will not attempt to discuss the many problems that have come up in administering such a program as this. I do believe that the following is an example of how our office has tried to use the complaints that have come to us to good advantage in meeting the many problems that face the administrator of such a program. One tumor clinic director advised me that I was going to get a stinging letter from a physician who was disturbed about the way health department personnel were urging private patients to go to the tumor clinics as indigent patients. I waited several weeks for this letter, and when it did not come, I decided to write the physician directly, asking him for his letter. The physician gave me the story of his complaint. The matter was investigated, and it was found that the physician had been improperly informed, and his complaint was entirely unjustified. We believe that we have a much better understanding with this physician because of this experience, and we have continually welcomed complaints from any physician in the state. Efforts have been made to clarify misunderstandings from time to time by direct discussion with individual physicians. It is realized that in the administration of any type of program such as the Cancer Control Program complaints will continually arise; however, we believe that most of these complaints can be settled, if we are informed of the complaints, and the attending physician is willing to look into the case thoroughly, and the majority of the physicians are. We welcome complaints and sometimes we find they are justifiable.

Special Study

In September 1951 it was decided by the State Health Officer, Dr. Wilson T. Sowder, that it would be a worth while study to make an inventory, as we might call it, to see if patients are slipping through the tumor clinics that should be treated by private physicians. It was decided to study the first 100 cases approved for state aid in which the patients were received during the month of August 1951. These cases were found to be distributed over the state in 39 different counties. They extended from Escambia County at one extreme point in the state to Monroe County at the other. It was thought that such a study would determine if our plan of operation was sound and at the same time flexible enough to provide for prompt services to the patient, with as little "red tape" as possible to entangle the patient and the physician in their efforts to cure the condition.

Because of the wide distribution of the cases over the state, it was thought advisable to secure interviewers who lived as near the patients as possible. We were able to secure the part time temporary services of 11 experienced, well qualified social workers, who because of personal responsibilities were not available for full time employment. In addition to a saving in expense for travel, this arrangement had the added advantage of providing interviewers who were already familiar with the local conditions in the area to which they were assigned.

The first task of the social worker was to prepare a detailed questionnaire to be used by the 11 part time social workers. This questionnaire included information obtained from an interview with the referring physician and the county health

officer, the number of persons in the household, amount of income, any pensions, amount of real estate owned, if any, amount of life insurance, health insurance, bank accounts, postal savings, hospital insurance, whether the patient owned a car, and, if so, the make, model and amount of monthly payments. Expenses of the patient as to rent, medical bills, other unusual expenses, and debts other than mortgages were also included. In addition, information as to whether or not the patient had been receiving welfare through public assistance and whether or not the patient was a resident of Florida was sought, as was any other information that would be of value in determining whether or not the patient was indigent.

Since the primary focus of the study concerned the status at the time of certification for state aid, it was thought reasonable to assume that those persons receiving public assistance, or dependent upon public assistance, could be classified as medically indigent. Clearance with the State Department of Public Welfare and local county welfare agencies revealed that in 40 of the 100 cases being studied the patients were at the time of certification receiving assistance or were accepted as eligible for such assistance within a few weeks after certification. In these 40 cases, therefore, the patients were accepted as being medically indigent without further investigation. In the remaining cases, the patients were interviewed in their homes, and other information was obtained through the health officers and attending physicians.

No attempt was made to define or establish a simple standard for eligibility for financial assistance. Income alone is not a clear indication of a family's financial situation, but must be considered in the light of many factors, such as family responsibilities, the effect of illness on the income of wage earners, the cost to families of providing for unusual expenses, such as housekeeping services if the mother of small children is ill, the prognosis of the case, and other factors. Both income and resources have to be evaluated in relation to the family's indebtedness and future prospects. An attempt was made, therefore, to secure information regarding both income and resources, such as life insurance, real estate and bank accounts, and to show as clearly as possible if these were adequate to meet the particular family's reasonable requirements.

An additional consideration in this program is the probable cost of the diagnosis and treatment if the patient had to secure them through private sources. Many families could, without difficulty, pay a $20 or $25 bill for treatment. Many of these same families could not, however, assume full responsibility for extensive surgery and lengthy hospitalization. For this reason the material secured by the interviewers in each case was studied in relation to the total amount of expenses by the state for treatment and diagnosis, and the probable cost had this service been sought through private sources by the patient.

Out of the 100 cases selected, it was not possible to locate 4 patients. The circumstances of 3 of the 6 deceased were not known; the remaining 3 were public assistance recipients. In 40 of the 100 cases the patients were public assistance recipients and assumed to be eligible. Fifty-three complete studies, therefore, were made:

Public assistance recipients	40
Unable to locate	4
Deceased, financial circumstances unknown	3
Studies completed	53
Total	100

As income is the major single factor in determination of eligibility in some cases, it was necessary to estimate income received through odd jobs and farming. Net income on cash crops was estimated and included, as well as value to the family of vegetable gardens, poultry, and other items. Pensions from private or governmental sources were also included.

Incomes of patients certified for state aid were as follows:

Single persons	
$75 monthly or less	4
Families (2 or more)	
$150 monthly or less	33
Families (2 or more)	
$150-$200 monthly	5
Families (2 or more)	
$200-$250 monthly	4
Families (2 or more)	
$250-$325 monthly	5
Unknown	2
Total	53

Twenty-three patients, or their families, owned or were buying their homes. The highest valuation on a homestead was $7,000. Tax receipts were checked as substantiating evidence as to the value of the property reported. One patient reported

real estate other than a homestead. This was two unimproved lots valued at $600 and mortgaged for $400, which had been used to pay the cost of medical treatment for cancer.

Thirty-seven families carried some form of life insurance. In 35 cases there was no cash or loan value, or the amount was small, the policies being industrial policies of $500 or less face value. Five of the families had some form of health insurance. Six carried hospital insurance. Thirty-three of the 53 families did not own automobiles.

Five families owned Chevrolets:

1 1934
1 1940
1 1941
1 1942
1 1949

Six families had Chevrolet trucks:

1 1935
1 1937
1 1939
1 1942
1 1946
1 1949

One family owned a Dodge:

1 1940

Six families owned Fords:

2 1936
2 1940
1 1941
1 ..... 1951 (owned by patient's son)

One family owned a Pontiac:

1 1940

The persons initiating the application for state aid were in 18 cases private physicians other than the tumor clinic directors. Four applications were signed by the county health officer through referral by private physicians. Applications in 22 cases were signed by tumor clinic directors. Applications were signed and referred by health officers in 9 cases. Persons certifying that the patient was indigent were approved by the county health nurse or secretary in 10 cases, by the tumor clinic director in 1 case, and by the tumor clinic personnel (secretary or nurse) in 14 cases. The county health officer interviewed the patients in 10 cases. The hospital social service or credit department interviewed the patient in 4 cases. It was undetermined as to who interviewed and approved in 6 cases.

The system seems to vary in the different counties in which a tumor clinic is located as to how the patients are first seen. Many patients go directly to the clinic because they have heard of the services, or were told to go there by their own physician. In rural areas the private physician usually refers patients to the county health office where applications are made. In some rural areas the patients go directly to the county health office and are interviewed.

In three of the counties a cooperative agreement has been made with the local welfare agency to certify as to the financial status of persons applying for state aid. Eighteen of the 53 cases were reviewed with the local welfare agencies to determine if they had knowledge of the family situation in these cases. In only 1 case was a home visit made; however, it should be noted that in many situations the referring physicians, county health nurses, and others had a general knowledge of the family's situation.

It is clear from this study that there is a wide variation in the procedures for referral and for establishing medical indigence. This flexibility appears to have made it possible for the patients to receive medical care more promptly and for county health officers to use the assistance of welfare agencies where such facilities exist. One interviewer commented, "I enjoyed seeing a program at work where need is being met expeditiously and adequately."

There are obvious potential difficulties in so flexible an approach in establishing the need of patients for tumor clinic services, both as to the need for medical attention and ability to pay for care. Careful consideration should be given, however, to the financial cost of other procedures and the danger of delay in diagnosis and treatment of the disease under a more rigid system.

It is interesting to note that of the 100 cases in which patients were referred to the tumor clinics, in 29 the disease was nonmalignant. In 57 malignant disease was present, and diagnosis was incomplete in 14 cases.

Time will not permit a detailed report on individual cases, but a detailed report was prepared and presented to a committee of three, two practicing physicians and a medical social worker, for their opinion as to whether or not in some cases the patient was indigent. The following cases are illustrative.

There were four in one family and an income of $303 monthly from the patient's earnings. The patient had a wife and two children of preschool age. A monthly payment on the house of $65 had to be met, and there were no other resources. Diag-

nosis was: "Giant follicular lymphoblastoma with lymphosarcoma." Clinic recommendations were roentgen ray treatments. The state paid $78 for 39 treatments. The cost of treatment was not covered by hospital insurance carried by the patient.

There were two in another family with $182 a month from the patient's employment. The wife did seasonal work, but was not employed at the time of application. The patient owned a home valued at $2,500. This was a case of both basal cell lesions and squamous cell lesions in different multiple sites including the left nasolabial fold, right ear and cheek.

It was the opinion of the committee reviewing the findings of the social service worker on the individual cases that, in their opinion, in all of the cases approved for state aid the patients were medically indigent.

This same detailed report was submitted to the Florida Cancer Council for the opinion of its members, and with possibly one or two exceptions they agreed that the patients were all medically indigent.

Summary

On the basis of this study of 100 cases, it would appear that all of the patients, with the exception perhaps of 1 or 2, were justly classified as medically indigent. Hence, they were eligible for state aid treatment under the Cancer Control Program. Methods of determining indigence varied widely, according to the facilities available in the counties; but the emphasis seems to have been on securing prompt treatment for those suspected of having cancer who appeared to be unable to pay for the cost of service.

The system used by the county health department, the tumor clinic directors and the State Board of Health seems to be a practical plan for determining medical indigence.

If an adequate number of social service workers were to be employed to check on each individual case, the cost of such a staff would be prohibitive. In general, it appears to be more economical to have an occasional study made such as the one completed last fall, which was inexpensive in comparison with the cost of a full time staff.

1217 Pearl Street.

Discussion

Dr. Edward R. Smith, Jacksonville: When the cancer study which has just been reported was completed, it was deemed advisable to conduct a similar study on the distribution of insulin, an activity of the State Board of Health since 1935, when it was initiated by legislative act.

There have been many efforts by county health officers to distribute the available supply of insulin on an equitable basis. One of the purposes of this study was to review the methods used to evaluate those which were believed to be most satisfactory.

The study was begun in January of this year by essentially the same staff as for the cancer study. The sample was picked by taking every eighth case in which the patient had received insulin between the dates, April 1, 1951 and July 1, 1951. The cases selected fell in 57 counties.

In those cases in which the patient was receiving public assistance or was dependent on a recipient of public assistance, he was deemed eligible, and studies were not made. Public assistance for the purpose of this study was considered to be assistance to a family or a person from a tax-supported agency. Verification of the public assistance was made through the State Department of Welfare and/or local welfare agencies. It was thought that income alone was not a clear indication of a family's financial situation. Both current income and resources such as life insurance were investigated to determine if these were adequate to meet reasonable family needs. In addition to financial information, an attempt was made to evaluate the patient's adjustment to his disease. The interviewers secured such pertinent information as duration of the diabetes, disabling complications and adjustment. Also, if the patient had discontinued insulin, he was questioned as to the reason.

The study consisted of an analysis of 202 cases. They fell into the classifications given below:

Deceased	11
Unable to locate	12
Public assistance	105
Patient at State Tuberculosis Hospital	1
Refused to give information	4*
Studies completed	69
Total	202

As income is the major single tangible factor in determining eligibility, the 69 cases were broken down into the following classifications:

Income less than $100 monthly	35
Income $100-$149 monthly	14
Income $150-$199 monthly	10
Income $200 and over monthly	10
Total	69

It was believed that those persons and families with incomes of less than $100 per month could not carry the full cost of medical treatment for diabetes without undue hardship. Persons in this category, therefore, were considered eligible without further consideration.

Of the 14 with incomes from $100 to $149 there were 2 single persons. One was apparently not eligible, and insulin had been discontinued prior to the study. The other, recently widowed, had voluntarily withdrawn from the free insulin service. She, however, would probably be eligible. Of the 12 remaining families, 8 consisted of 2 persons and 4 of 3 persons or more. The patients in these families were all clearly eligible.

In the income bracket $150-$199 monthly there were no single persons. There were 10 families, 5 of which had 4 or more members. In the single 2 member family, the patient was buying over half of the insulin required.

In the income bracket of $200-$300 there were 10 families, 7 of which had 3 or more members. Three of the families were comprised of 7 or more persons, and the patient in each was considered eligible. In 3 families the patient had been found ineligible prior to the time of the study, and free insulin had been discontinued. Patients in 2 families would probably be ineligible, but are still receiving free insulin.

Disabling conditions resulting from diabetes were reported by 60 of the 69 patients interviewed. These varied from total blindness and the loss of one or both legs to milder conditions which left the patient able to perform his usual duties. In 30 of these cases the disability caused

loss of income. Because of diabetes, 2 boys aged 16 had discontinued school.

All of the county health officers were interviewed, and suggestions were solicited. Some have worked out satisfactory arrangements with local welfare agencies, but some make no attempt to establish indigence and dispense insulin when the client is referred by a physician. A number of county health officers thought that some procedure, such as a form for interviewing patients applying for insulin, would be helpful, but others who have close association with welfare agencies did not agree. Still others were of the opinion that anything added to the present plan or any change in the present plan would make the distribution less efficient. The health officers have met the problem of decreased supply of insulin in various ways, varying from giving part of the insulin to dispensing the supply on a "first come first served" basis. A few report that the supply is approximately adequate.

Since the decrease in the appropriation for the purchase of insulin, there has been much closer screening of applicants for this service. This is clearly shown by the fact that only 3 patients probably ineligible are still receiving free insulin. It is apparent, however, that a clear definition of responsibility and the agreement on a basic policy would result in a more equitable distribution of available supplies of insulin. From these studies it is apparent that there is little abuse of these assistance programs.

*None of these patients had received free insulin in some months. Two were found ineligible by the Health Department, and free insulin had been discontinued.

ABSTRACTS OF MEDICAL ARTICLES

Urinary Colloids in the Prevention of Kidney-Stone Formation. By Arthur J. Butt, M.D., and Ernest A. Hauser, Ph.D. New England J. Med. 246:604-607 (May 1) 1952.

The authors discuss crystalloid and colloid factors relating to calculus formation in the urine. Observing that many interpretations of stone formation have suggested unbalance between colloids and crystalloids as a basic cause, they note that medical literature shows a lack of information concerning further investigations of this unbalance and a disregard of valuable information that colloid chemistry could offer. Their interpretation is that the protective action of these colloids is important in preventing precipitation, agglomeration and conglomeration of crystalloids. If the concentration of such protective colloids is insufficient, however, then the crystal nuclei are sensitized and stone formation is accelerated.

They make the following inferences regarding the importance of the crystalloid and colloid factors:

Kidney stone formation may be controlled by the concentration of lyophilic colloids in the urine; presumably, the higher the concentration, the less noticeable the stone formation.

Stone formation may be brought about either by the growth of crystals from a highly concentrated electrolyte solution or by the agglomeration of the dispersed phase of inorganic colloids due to a reduction of their zeta potential in the presence of a high concentration of counter ions.

In the presence of hydrophilic colloids, the electrolytes are thought to bring about gelation, if present in high concentration, embedding the inorganic matter in the gel. The hydrophilic colloid, if capillary-active, may also act as a peptizing agent and protective colloid, thereby preventing growth or agglomeration.

The use of strong peptizing agents, such as hyaluronidase, may reduce stone formation.

The Present Status of Phrenic Nerve Paralysis in the Treatment of Pulmonary Tuberculosis. By Hawley H. Seiler, M.D., M.S. (Surg.), F.C.C.P. Dis. of Chest 21:578-584 (May) 1952.

Dr. Seiler evaluates the role of phrenic nerve paralysis as a collapse procedure in the treatment of pulmonary tuberculosis, a form of therapy now used less frequently and with more discrimination than in former times. He cites the indications for phrenic paralysis and describes briefly the technic of operation.

It is his conclusion that temporary phrenic paralysis is occasionally indicated in certain selected cases in the modern treatment of pulmonary tuberculosis, but should be performed only following a consideration of the patient's long range plan of therapy and possible future major surgical requirements. Permanent phrenic paralysis, in his opinion, has little place in present day treatment of pulmonary tuberculosis. He observes, however, that in a definite percentage of cases, attempted temporary phrenic paralysis will result in some degree of permanent impairment of diaphragmatic function.

A New Female Air Cysto-Urethroscope. By David W. Goddard. J. Urol. 67:526-528 (April) 1952.

The author describes a new female air cystourethroscope designed so that it combines the best features of the Kelly and Koch instruments and avoids the undesirable features of both. It is believed that this instrument provides better vision and greater usability for the urologist who uses the air cystourethroscope in a limited way than any instrument previously available. It may be obtained from V. Mueller and Company, Chicago.

The Problem of "Sore Throat" with Special Reference to Modern Therapy. By A. R. Hollender, M.D. South. M. J. 45:619-625 (July) 1952.

Defining "sore throat" as a generic term embracing a multiplicity of pathologic processes and implying a painful state of the pharynx, the author approaches his subject from the clinical viewpoint of (1) "sore throat" which restricts itself to the site of infection at the portal of entry, with Plant-Vincent's angina as an example, and (2) "sore throat" which progresses to other diseases, as anterior poliomyelitis.

After commenting on local and metastatic infection, he discusses the throat with the tonsils in and the throat with the tonsils out, and then deals with special types of "sore throat," notably in children and in older persons, epidemic, traumatic, viral, carrier, abscess, post-tonsillectomy, smoker's and allergic — also "sore throat" influenced by emotional factors, in blood dyscrasias and in tuberculosis, syphilis and other diseases.

Under modern therapy the acute and the chronic "sore throat" are discussed, and in addition granular, lateral and atrophic pharyngitis and chronic hypertrophic tonsillitis. It is observed that in "sore throat" the newer antimicrobial agents represent an outstanding therapeutic advance in combating the acute infection, but one should remember that other processes are provoked thereby, and that these require separate and distinct management. In children and in adults, if the tonsils are chronically diseased, surgical tonsillectomy is advised as unquestionably the procedure of choice. For children who cannot be subjected to operation, roentgen radiation is regarded as the preferred substitute. For older persons, in whom contraindications to surgical intervention exist, electrosterilization of the tonsils is advocated as an effective prolonged palliative.

Buphthalmos: Results from Operative Procedures Particularly Cyclodiathermy: Report of Six Cases. By S. B. Forbes, M.D. Am. J. Ophth. 35:393-398 (March) 1952.

In this paper the author presents 6 illustrative cases to support his conclusion that certain early and late cases of buphthalmos respond to some of the older therapeutic procedures, especially cyclodiathermy used conservatively. In 5 of the cases intraocular surgery produced little improvement in the intraocular pressure, but cyclodiathermy effected its control.

In nine of the 10 eyes the intraocular pressure was normalized. In one eye it was fairly normal with the use of miotics. In 1 case, cyclodialysis was followed by cyclodiathermy in 1943 when the patient was only a few weeks old; the child is now in school and able to carry on well. In another case, satisfactory results were obtained by an iris-inclusion operation in one eye and an iris-inclusion operation combined with a corneosclerectomy in the other eye. The corneal haze cleared sufficiently to give a clear view of the grounds, and there was great improvement. Global shrinkage, which has been feared in this type of surgery, developed in none of the 10 eyes.

Primary Ulcer of the Jejunum. By Maurice Rich, M.D., and Maxwell M. Sayet, M.D. Rev. Gastroenterol. 18:895-902 (Dec.) 1951.

A case, with autopsy, of simple or nonspecific ulcer of the jejunum with melena complicated by an acute myocardial infarction is described. The etiology, pathology, symptomatology, diagnosis and treatment of this rare condition, found fortuitously, are discussed. A pertinent review of the literature on this subject is also presented and indicates that this case brings the total number reported to 78.

Psittacosis. By Theodore F. Hahn, Jr., M.D. Cyclopedia of Medicine, 1952, vol. 11, pp. 403-413.

This comprehensive presentation of the subject of psittacosis, with extensive bibliography, covers well the various aspects. These include synonyms, definition, distribution, varieties, etiology, pathogenesis, and pathology of the respiratory, gastrointestinal and central nervous systems, the spleen, and the kidneys. Also covered are symptomatology, complications, diagnosis, prognosis, prophylaxis and treatment. There is, in addition, a section on psittacosis in animals.

FLORIDA MEDICAL ASSOCIATION

OFFICERS AND COMMITTEES

OFFICERS

ROBERT B. MCIVER, M.D., President.....*Jacksonville*
FREDERICK K. HERPEL, M.D., Pres.-elect..*West Palm Beach*
FRANCIS H. LANGLEY, M.D., 1st Vice Pres...*St. Petersburg*
ERASMUS B. HARDEE, M.D., 2nd Vice Pres.....*Vero Beach*
H. QUILLIAN JONES, M.D., 3rd Vice Pres.....*Fort Myers*
SAMUEL M. DAY, M.D., Sec'y-Treas.....*Jacksonville*
SHALER RICHARDSON, M.D., Editor.....*Jacksonville*

MANAGING DIRECTOR

STEWART G. THOMPSON, D.P.H.....*Jacksonville*
ERNEST R. GIBSON, Assistant.....*Jacksonville*

BOARD OF GOVERNORS*

ROBERT B. MCIVER, M.D., Chm...(Ex Officio) .*Jacksonville*
JAMES L. BORLAND, M.D...AL-53.....*Jacksonville*
DUNCAN T. MCEWAN, M.D...B-53.....*Orlando*
JAMES H. POUND, M.D...A-54.....*Tallahassee*
NORVAL M. MARR, M.D...C-55.....*St. Petersburg*
JOHN D. MILTON, M.D...D-56.....*Miami*
HERBERT E. WHITE, M.D...PP-53.....*St. Augustine*
DAVID R. MURPHEY, JR., M.D...PP-54.....*Tampa*
FREDERICK K. HERPEL, M.D. (Ex Officio).*W. Palm Beach*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*
HERBERT L. BRYANS, M.D...S.B.H.-53.....*Pensacola*
STEWART G. THOMPSON, D.P.H. (Advisory)...*Jacksonville*

*SUB-COMMITTEES

1. Veterans Care
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
GEORGE M. STUBBS, M.D.....*Jacksonville*
DOUGLAS D. MARTIN, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

2. Advisory to National Foundation Infantile Paralysis
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
H. PHILLIP HAMPTON, M.D.....*Tampa*
ROBERT P. KEISER, M.D.....*Coral Gables*
RICHARD G. SKINNER, JR., M.D.....*Jacksonville*

3. Review of Fee Schedules
JOHN D. MILTON, M.D., Chm.....*Miami*
WOODROW B. ESTES, M.D.,.....*St. Petersburg*
FREDERICK H. BOWEN, M.D.....*Jacksonville*
ODIS G. KENDRICK, JR., M.D.....*Tallahassee*
JAMES B. GLANTON, M.D.....*Orlando*
FLOYD K. HURT, M.D.....*Jacksonville*
HERSCHEL G. COLE, M.D.....*Tampa*
A. FRANKLIN HARRISON, M.D.....*Madison*
JACK O. W. RASH, M.D.....*Miami*
KENNETH S. WHITMER, M.D.....*Miami*
ADELBERT F. SCHIRMER, M.D.....*Orlando*

1. Blue Shield
LEIGH F. ROBINSON, M.D., Chm.....*Fort Lauderdale*

SCIENTIFIC WORK

JAMES N. PATTERSON, M.D., Chm...AL-53.....*Tampa*
CAROL C. WEBB, M.D...A-53.....*Pensacola*
FREDERICK K. HERPEL, M.D...D-54.....*West Palm Beach*
JERE W. ANNIS, M.D...C-55.....*Lakeland*
RICHARD C. CUMMING, M.D...B-56.....*Ocala*

LEGISLATION AND PUBLIC POLICY

H. PHILLIP HAMPTON, M.D., Chm...B-53.....*Tampa*
WILLIAM M. ROWLETT, M.D...AL-53.....*Tampa*
DANIEL A. MCKINNON, M.D...A-53.....*Marianna*
ANGUS D. GRACE, M.D...C-55.....*Fort Myers*
DONALD W. SMITH, M.D...D-56.....*Miami*
ROBERT B. MCIVER, M.D. (Ex Officio).....*Jacksonville*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*

MEDICAL EDUCATION AND HOSPITALS*

JACK Q. CLEVELAND, M.D., Chm...AL-53.....*Coral Gables*
JULIUS C. DAVIS, M.D...A-53.....*Quincy*
ELBERT MCLAURY, M.D...D-54.....*Hollywood*
S. CARNES HARVARD, M.D...C-55.....*Brooksville*
BENJAMIN F. DICKENS, M.D...B-56.....*Fernandina*

*SPECIAL ASSIGNMENT

1. Urge Gifts to American Medical Education Foundation

PUBLIC RELATIONS*

EUGENE B. MAXWELL, M.D., Chm...AL-53.....*Tampa*
LEIGH F. ROBINSON, M.D...D-53.....*Fort Lauderdale*
HOWARD V. WEEMS, SR., M.D...C-54.....*Sebring*
EUGENE G. PEEK, JR., M.D...B-55.....*Ocala*
HENRY L. SMITH, JR., M.D...A-56.....*Tallahassee*

*SPECIAL ASSIGNMENTS

1. Rural Educational Program
2. State Education Campaign

NECROLOGY

ALVIN L. STEBBINS, M.D., Chm...A-56.....*Pensacola*
HUGH WEST, M.D...AL-53.....*DeLand*
JOSEPH HALTON, M.D...C-53.....*Sarasota*
WALLACE H. MITCHELL, M.D...D-54.....*Key West*
JOSEPH J. LOWENTHAL, M.D...B-55.....*Jacksonville*

MEDICAL POSTGRADUATE COURSE

TURNER Z. CASON, M.D., Chm...B-55.....*Jacksonville*
ARTHUR J. BUTT, M.D...AL-53.....*Pensacola*
FRANZ H. STEWART, M.D...D-53.....*Miami*
J. BROWN FARRIOR, M.D...C-54.....*Tampa*
FRANCIS T. HOLLAND, M.D...A-56.....*Tallahassee*

CANCER CONTROL

FRAZIER J. PAYTON, M.D., Chm...D-54.....*Miami*
MILTON C. MALONEY, M.D...AL-53.....*Jacksonville*
ROBERT L. TOLLE, M.D...B-53.....*Orlando*
GEORGE W. MORSE, M.D...A-55.....*Pensacola*
WESLEY W. WILSON, M.D...C-56.....*Tampa*

MEDICAL ECONOMICS

REUBEN B. CHRISMAN, JR., M.D., Chm...AL-53....*Miami*
JOHN E. MAINES, JR., M.D...B-53.....*Gainesville*
HARRISON A. WALKER, M.D...D-54.....*Miami*
WILLIAM H. WALTERS, JR., M.D...C-55.....*Lacoochee*
WILLIAM C. ROBERTS, M.D...A-56.....*Panama City*

VENEREAL DISEASE CONTROL

MELVIN M. SIMMONS, M.D., Chm...C-55.....*Sarasota*
JOHN R. BROWNING, M.D...AL-53.....*Jacksonville*
JOHN C. MCSWEEN, JR., M.D...A-53.....*Pensacola*
WILEY M. SAMS, M.D...D-54.....*Miami*
DAVID W. GODDARD, M.D...B-56.....*Daytona Beach*

TUBERCULOSIS AND PUBLIC HEALTH*

RALPH S. SAPPENFIELD, M.D., Chm...AL-53.....*Miami*
PHILLIP W. HORN, M.D...B-53.....*Jacksonville*
ERASMUS B. HARDEE, M.D...D-54.....*Vero Beach*
LOUIS J. GARCIA, M.D...C-55.....*Tampa*
HARRY S. HOWELL, M.D...A-56.....*Lake City*

*SPECIAL ASSIGNMENT

1. Diabetes Control

STATE CONTROLLED MEDICAL INSTITUTIONS

William D. Rogers, M.D., Chm...A-56....*Chattahoochee*
James L. Anderson, M.D...AL-53.....*Miami*
Bailey B. Sory, Jr., M.D...D-53.....*Palm Beach*
James G. Lyerly, M.D...B-54.....*Jacksonville*
Samuel G. Hibbs, M.D...C-55.....*Tampa*

MATERNAL WELFARE

E. Frank McCall, M.D., Chm...B-56.....*Jacksonville*
T. Bert Fletcher, Jr., M.D...AL-53.....*Tallahassee*
Lowrie W. Blake, M.D...C-53.....*Bradenton*
John N. Sims, Sr., M.D...A-54.....*Live Oak*
Ralph W. Jack, M.D...D-55.....*Miami*

CHILD HEALTH

Luther W. Holloway, M.D., Chm...B-53....*Jacksonville*
James R. Boulware, Jr., M.D...AL-53.....*Lakeland*
Warren W. Quillian, M.D...D-54.....*Coral Gables*
Daniel F. H. Murphey, M.D...C-55.....*St. Petersburg*
Courtland D. Whitaker, M.D...A-56.....*Marianna*

CONSERVATION OF VISION

Ralph N. Greene, Jr., M.D., Chm...AL-53..*Jacksonville*
William Y. Sayad, M.D...D-53.....*West Palm Beach*
Sherman B. Forbes, M.D...C-54.....*Tampa*
G. Tayloe Gwathmey, M.D...B-55.....*Orlando*
Mozart A. Lischkoff, M.D...A-56.....*Pensacola*

ADVISORY TO WOMAN'S AUXILIARY

C. Robert DeArmas, M.D., Chm...B-55....*Daytona Beach*
Benjamin H. Sullivan, M.D...AL-53.....*St. Petersburg*
Edward F. Shaver, M.D...C-53.....*Tampa*
James L. Anderson, M.D...D-54.....*Miami*
Taylor W. Griffin, M.D...A-56.....*Quincy*

REPRESENTATIVES TO INDUSTRIAL COUNCIL*

Charles R. Burbacher, M.D., Chm...D-55..*Coral Gables*
Fred H. Albee, Jr., M.D...AL-53.....*Orlando*
G. Frederick Oetjen, M.D...B-53.....*Jacksonville*
Chas. L. Farrington, M.D...C-54.....*St. Petersburg*
Lee Sharp, M.D...A-56.....*Pensacola*

*SPECIAL ASSIGNMENT

1. *Industrial Health*

COUNCILOR DISTRICTS AND COUNCIL

Eugene G. Peek, Jr., M.D., Chm...AL-53.....*Ocala*
First—Francis M. Watson, M.D...1-54.....*Marianna*
Second—Benjamin A. Wilkinson, M.D...2-53.*Tallahassee*
Third—William C. Thomas, Jr., M.D...3-54..*Gainesville*
Fourth—Eugene L. Jewett, M.D...4-53.....*Orlando*
Fifth—Hugh G. Reaves, M.D...5-53.....*Sarasota*
Sixth—Emmett E. Martin, M.D...6-54.....*Haines City*
Seventh—Erasmus B. Hardee, M.D...7-54....*Vero Beach*
Eighth—Donald W. Smith, M.D...8-53.....*Miami*

GRIEVANCE COMMITTEE

Walter C. Payne, M.D., Chm.....*Pensacola*
David R. Murphey, Jr., M.D.....*Tampa*
Herbert E. White, M.D.....*St. Augustine*
Joseph S. Stewart, M.D.....*Miami*
William C. Thomas, Sr., M.D.....*Gainesville*

ADVISORY TO SELECTIVE SERVICE FOR PHYSICIANS AND ALLIED SPECIALISTS

J. Rocher Chappell, M.D., Chm.....*Orlando*
Thomas H. Bates, M.D..."A".....*Lake City*
Frank L. Fort, M.D..."B".....*Jacksonville*
Alvin L. Mills, M.D..."C".....*St. Petersburg*
John D. Milton, M.D..."D".....*Miami*

EMERGENCY MEDICAL SERVICE

James V. Freeman, M.D., Chm.....*Jacksonville*
Merritt R. Clements, M.D..."A".....*Tallahassee*
Vernon A. Lockwood, M.D..."B".....*St. Augustine*
Herschel G. Cole, M.D..."C".....*Tampa*
Frederick K. Herpel, M.D..."D".....*West Palm Beach*

A.M.A. HOUSE OF DELEGATES

Louis M. Orr, II, M.D., Delegate.....*Orlando*
Joshua C. Dickinson, M.D., Alternate.....*Tampa*
(Terms expire Dec. 31, 1953)

Reuben B. Chrisman, Jr., M.D., Delegate.....*Miami*
Frank D. Gray, M.D., Alternate.....*Orlando*
(Terms expire Dec. 31, 1954)

Herbert L. Bryans, M.D., Delegate.....*Pensacola*
Thomas H. Bates, M. D., Alternate.....*Lake City*
(Terms expire Dec. 31, 1954)

BOARD OF PAST PRESIDENTS

William E. Ross, M.D., 1919.....*Jacksonville*
H. Marshall Taylor, M.D., 1923.....*Jacksonville*
John C. Vinson, M.D., 1924.....*Fort Myers*
John S. McEwan, M.D., 1925.....*Orlando*
H. Mason Smith, M.D., 1926.....*Tampa*
John A. Simmons, M.D., 1927.....*Arcadia*
Frederick J. Waas, M.D., 1928.....*Jacksonville*
Julius C. Davis, M.D., 1930.....*Quincy*
William M. Rowlett, M.D., Chm., 1933.....*Tampa*
Homer L. Pearson, Jr., M.D., 1934.....*Miami*
Herbert L. Bryans, M.D., 1935.....*Pensacola*
Orion O. Feaster, M.D., 1936.....*Renton, Wash.*
Edward Jelks, M.D., 1937.....*Jacksonville*
Leigh F. Robinson, M.D., 1939.....*Fort Lauderdale*
Walter C. Jones, M.D., 1941.....*Miami*
Eugene G. Peek, Sr., M.D., 1943.....*Ocala*
John R. Boling, M.D., 1944, 1945.....*Tampa*
Shaler Richardson, M.D., 1946.....*Jacksonville*
William C. Thomas, Sr., M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne, M.D., 1949.....*Pensacola*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey, Jr., M.D., Sec'y., 1951.....*Tampa*

From Our President

Ring Out the Old
Ring In the New

Happy New Year to every member of the Florida Medical Association! With the advent of 1953 the medical profession is reminded once again of its perennial opportunity to be a happy profession. Striving as it does unceasingly, with sympathy and intelligence, for the relief of suffering, it enjoys a privilege not accorded to all men. To the relative few who willingly travel the long road of learning and discipline toward the goal of greater human health, happiness, and well-being go the abundant rewards of this self-imposed service.

As they begin the new year, men of medicine may heartily rejoice in the realization of the miracles already accomplished in the conquest of disease. At the same time, they should earnestly dedicate themselves to the quest for more knowledge and better tools to meet the problems as yet unsolved. The familiar words of Tennyson carry the challenge:

Ring out the old, ring in the new,
Ring, happy bells, across the snow:
The year is going, let him go;
Ring out the false, ring in the true.

The pursuit of happiness guaranteed by the Declaration of Independence is in itself a tremendous privilege. Who should be happier than physicians to engage in that phase of ringing in the true in this great country? This is still a land of plenty, a land of opportunity, truly an oasis in a troubled world. Here in an atmosphere of freedom, the medical profession has been privileged to progress and grow great in accomplishments and prestige.

There lie ahead, however, greater goals and, likewise, greater responsibilities. The responsibilities, rewards, rights and privileges are all intimately intertwined. Our rights and privileges, coming largely from without, belong also to our patients. We have then a dual motive for protecting these rights and fighting for them with all our strength; they are fundamental to the preservation of the attitudes and ideals which have given us our freedom.

Our illustrious predecessors set the pattern of reward by giving service in measure full and running over, seasoned well with charity. As with them so with us — the greatest satisfaction lies in healing.

Assuredly, in the new year the ever increasing responsibilities will be met in traditional fashion. We shall improve our technics, we shall seek ever higher standards both educational and ethical, and we shall cultivate proper public relations, all in order that our ultimate object of solicitude, the patient, will have the best medical care in the world. That is the road to happiness.

Robert B McRae

The Journal of the
Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. BOX 1018 JACKSONVILLE, FLORIDA

Editar
Shaler Richardson, M.D.

Assistant Editors
Webster Merritt, M.D.
Franz H. Stewart, M.D.

Associate Editars

Louis M. Orr, II, M.D. ..... Orlanda
Joseph J. Lawenthal, M.D. ..... Jacksonville
Jere W. Annis, M.D. ..... Lakeland
Herschel G. Cale, M.D. ..... Tampa
Wilsan T. Sawder, M.D. ..... Jacksonville
Carlas P. Lamar, M.D. ..... Miami
Walter C. Payne, M.D. ..... Pensacala

Managing Editor
Stewart G. Thompson, D.P.H.
Ernest R. Gibson, Asst.

Committee on Publicatian

Shaler Richardsan, M.D., Chairman ..... Jacksonville
Chas. J. Callins, M.D. ..... Orlanda
James N. Pattersan, M.D. ..... Tampa

Abstract Department

Kenneth A. Marris, M.D., Chairman ..... Jacksanville
Walter C. Janes, M.D. ..... Miami

"Let's All Eat Dirt"

Animal experimentation has been a great boon to medical science. The countless frustrated accusations by antivivisectionists have been adequately and factually answered by the medical and allied professions to the point where animal experiments are accepted as an essential part of medical progress by most emotionally stable people.

Any true medical investigator realizes that animal experiments are only what the name implies. What holds true for one animal may not hold true for animals of the same species. Hence, while knowledge from animal experiments gives insight into a problem, these experiments are not the sine qua non of allopathic medicine today. Were this so, the studies of comparative anatomy and comparative physiology would be superfluous.

Any science is based on facts. Facts are immutable. Any science must perforce have theories based on facts or that science would stagnate. Although medicine is not a true nor pure science, it derives its fundamentals from enough pure sciences to preclude any air of illegitimacy. Thus we physicians are men of science and hence should base most of our actions on facts.

A few years ago it was noted that cattle grazing in certain areas were larger and healthier than those in other areas. By soil analysis it was found that the healthier cattle were grazing on lands richer in certain elements now called trace minerals of the human body. Ergo, if cattle were healthier eating grass with these minerals, why would not people also be healthier?

From small acorns mighty oaks grow. From one small pharmaceutic firm adding trace minerals to its vitamin capsules, even the giants of the industry now add trace minerals to their preparations. In detailing their products these same companies invariably will quote the aforementioned animal studies to prove their point. To prove what point? That we are cows? If we blindly believe every drug advertisement we read or every detail we hear, we are indeed cattle and probably do need trace minerals added to capsules so potent in vitamins that most of them are excreted in the urine.

Several months ago the newspapers contained accounts of women who would have a desire to and did eat dirt at various times. It was soon discovered that this dirt eating was on the basis of hysteria rather than the body satisfying any great need for trace minerals. Because of the publicity given to these bovine humans, the drug companies did not use this phenomenon as evidence furthering their claims of the necessity of trace elements or dirt in everyone's diet. Scientifically speaking, it was, however, a much more critical and pertinent experiment. It was a true in vivo experiment without the vitiating factor of species variation.

American physicians can well be proud of their pharmaceutic industry. It has no peer. Yet

no matter how altruistic drug companies may deem themselves, they are still in business to make money. To accomplish this purpose, not only have they sugar coated their bitter pills, but they have also adopted the finest type of advertising available. So fine is it, in fact, that they are able to convince the profession which fostered and nurtured them from small apothecary shops to multimillion dollar industries that they now know both literally and figuratively what is best for the doctor.

It would indeed be absurd to try to convince the public at this time that most of the vitamins they now so faithfully take one or more times daily are one or more times daily passed out in their excreta. Many physicians themselves have been convinced that the cure for anorexia, fatigue, anxiety neuroses, et cetera, is merely a "shot" of vitamin B_1, B_{12} or B_{96}. Fortunately, the ill effects of vitamin therapy are not common and the fatalities from their parenteral administration not well enough publicized to put any brake on their usage. Time alone will finally put vitamin therapy in its proper place in the therapeutic armamentarium.

Yet even before the paretic expansive claims for vitamin therapy have died down, another panacea looms on the medical horizon — that of trace minerals. It is easy to imagine the wonderful articles soon to be published in various pocket-sized magazines telling how no one can be healthy unless he has an abundance of trace minerals in his diet. Trace minerals will soon be in our food, tooth paste and cigarettes. Perhaps our bovine sisters of the Bayou region were not so hysterical after all. Let's be certain we all get our minimal daily requirement of trace minerals. Let's all eat dirt and be as contented as cows!

RESERVE THESE DATES

APRIL 26, 27, 28, 29, 1953

FOR THE CONVENTION IN

HOLLYWOOD

New Horizons

When asked, after the ratification of the Constitution of the United States, what sort of a government we have, Benjamin Franklin is said to have remarked, "A republic — if you can keep it." Emphatically, the American people have decided to keep it — at least for the ensuing quadrennium.

It would appear that with the incoming of the new administration and the opening of the Eighty-Third Congress this month, there will come to the physicians of the country the opportunity to devote more of their time and energy to a sound, constructive and unselfish program of better medical care for all the people — a program unhampered by politics. Gone from the Federal Security Administration will be the little man who not only diagnosed a major ailment creeping up on the nation, but persistently, indeed blatantly, proposed a remedy for it. The ailment? A big percentage increase in older Americans. The remedy? Bringing the physicians of the nation under the control of politicians and bureaucrats and dragooning them all into a system of compulsory health insurance. Ewingism — happily — will be missing from the American scene in 1953.

Even so, there is no room for complacency, now or ever again, in the kind of world in which we live. Although the people have spoken loudly and clearly through the ballot, their enemies will not fold up their tents and silently steal away. There remain always those who seek to sneak in by the rear door or the side entrance when the front door has been shut in their faces. Surely the medical profession has learned to keep ever alert lest our adversaries try to climb up some other way.

New horizons, vast indeed and as yet unexplored, lie before us. Yesterday's distant landmark today is reached and tomorrow is left behind. Now that the tide of socialism has been turned back, our nation's immense potentialities are unlimited — provided always that we possess the courage, under God, to develop them. We of the medical profession have the vision. Ours is the constructive imagination, ours the creative spirit that ever improves the chances for a longer and also a happier and healthier existence for the world's teeming millions. Let us then lead on this year, confident in the reasonable certainty that the remaining scourges of man will not only be held in check but eventually eliminated.

Prescription Regulations

A modified series of regulations bringing federal prescription requirements into conformity with the new Durham-Humphrey Act (P.L. 215, 82nd Congress) has been issued by the Food and Drug Administration, acting through the Federal Security Administrator. These final regulations (1) provide a labeling guide to manufacturers on directions for use of drugs; (2) continue labeling exemptions for physicians; (3) tighten up rules to make certain that prescription drugs are dispensed only by or on the prescription of a physician or other licensed practitioner; and (4) exempt certain habit-forming drugs from the prescription-only restrictions when used in nonhazardous combinations.

The new regulations are an amended version of proposed regulations published in February; they do not, however, attempt to rule on certain points in dispute since then. Specifically, they do not mention prohibiting sale by mail of prescription drugs, do not attempt to define toxicity, and do not apply "method of use" as a criterion for prescription-only designation. All injection drugs except insulin were listed as prescription-only in the proposed regulations. The Food and Drug Administration is reserving the right to rule on these controversial points in the future, but a spokesman said the agency preferred not to delay longer the official publication of regulations on which there is substantial agreement among the pharmaceutical industry and the medical profession.

The final regulations are published in the Federal Register for July 25 (Vol. 17, No. 145), and copies are available from the Food and Drug Administration, Washington 25, D. C.

Human Poisoning from Toxaphene

Chlorinated camphene, commonly known as toxaphene, is a recently developed insecticide which has demonstrated its effectiveness against a variety of agricultural and livestock insect pests. It has been used extensively against cotton insects and for the control of grasshopper infestations. It is also employed as a supplement to, and substitute for, DDT for the control of insects resistant to DDT. For household application, toxaphene sprays are not considered safe, nor have acceptable medicinal uses for this polychlor bicyclic terpene with insecticidal properties been discovered.[1]

The average empiric formula is $C_{10}H_{10}Cl_8$. The technical or insecticidal material is an amber waxy solid with a mild pinelike odor. It contains 67 to 69 per cent chlorine and melts at temperatures of 70 to 95 C. Toxaphene is insoluble in water, but readily soluble in inexpensive commercial solvents, especially those of an aromatic hydrocarbon nature. It is practically nonvolatile and has residual properties resembling those of DDT.

Oral toxicity of toxaphene places it among the more toxic of the commercially available chlorinated hydrocarbon insecticides which are acutely poisonous by this route of administration. It is believed to be approximately four times as acutely toxic as DDT. The fatal dose for man has been estimated to be 2 to 7 Gm.

Toxaphene is a general convulsant which acts on the central nervous system. It causes diffuse stimulation of the brain and spinal cord resulting in generalized convulsions of a tetanoid or clonic character, acting in this respect somewhat as DDT and certain other chlorinated hydrocarbon insecticides. In human poisoning from this agent, therefore, the symptoms to be expected are those of a convulsant drug affecting the brain and spinal cord. Generalized epileptiform convulsions are the outstanding feature in acutely intoxicated animals and are to be anticipated in humans.

Three deaths in children and 8 cases of nonfatal poisoning from the accidental ingestion of toxaphene preparations and residual amounts of the technical material alone and on edible crops were recently reported by McGee, Reed and Fleming.[2] They described two instances of group poisoning which followed ingestion of toxaphene-sprayed collard greens and chard, respectively. In 7 of 10 persons known to have eaten the contaminated greens, symptoms developed consistent with toxaphene poisoning as observed in laboratory animals. Their onset was abrupt and not associated with abdominal pain, involuntary vomiting or diarrhea. The illness was manifested by response of skeletal muscles to stimulation of the central nervous system and by loss of consciousness. In the 3 fatal cases, one child apparently ingested an amber-colored, beeswax-like material identified as toxaphene, another was believed to have ingested an unknown quantity of toxaphene emulsion in water, and the third child drank "about a half teaspoon" of a solution of toxaphene, presumably a 60 per cent concentration in special solvents being prepared for a tobacco spray. A fourth child "ingested a large amount of a chemical containing 20 per cent toxaphene," was in a critical condition

for several hours, but recovered with no untoward symptoms.

It is essential, these authors pointed out, that physicians recognize the cardinal symptom, a convulsion, and the importance of countering the acute stimulation of the central nervous system with barbiturates. Complete absence of poisoning in workers exposed to toxaphene suggests that it can be handled safely if used properly and with precautions against human consumption.

1. Pharmacologic Properties of Toxaphene, a Chlorinated Hydrocarbon Insecticide, J. A. M. A. 149:1135-1137 (July 19) 1952.
2. McGee, L. C.; Reed, H. L., and Fleming, J. P.: Accidental Poisoning by Toxaphene, Review of Toxicology and Case Reports, J. A. M. A. 149:1124-1126 (July 19) 1952.

North Florida Fair Exhibit

Second showing of the Florida Medical Association's fair exhibit took place Oct. 27-Nov. 1, 1952 during the North Florida Fair at Tallahassee. Sponsoring the exhibit was the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society. Dr. Francis T. Holland, Tallahassee, chairman of the Society's committee on public relations, was in charge of arrangements, assisted by Dr. Eugene B. Maxwell, chairman of the Florida Medical Association's Committee on Public Relations, and Mr. Tom Jarvis, assistant supervisor of the F. M. A. Bureau of Public Relations.

Dr. Francis T. Holland is shown checking the blood pressure of Mr. Tom Jarvis at the F. M. A. Fair Exhibit Booth at the North Florida Fair in Tallahassee. Observing are Dr. Edson J. Andrews (left) and Dr. Clarence W. Ketchum.

Dr. Clarence W. Ketchum had charge of blood grouping and typing and Dr. Mark Boyd supervised student nurses checking blood pressure. These two services were available from two to eight p.m. each day. The exhibit was open throughout the day and until 10 p.m.

Students and faculty members of the School of Nursing, Florida State University, were on duty to check blood pressures. Technicians from Florida State Hospital, Chattachoochee, the Gadsden County Hospital, Quincy, Leon County Blood Bank, Tallahassee, Tallahassee Memorial Hospital, and Florida State University Infirmary did blood grouping and typing. Members of the Woman's Medical Auxiliary living in Tallahassee assisted the technicians. The six hour period was broken into three shifts for student nurses and members of the Auxiliary, and into two shifts for technicians.

An estimated 4,000 persons saw the exhibit which was set up in tent number one in a space twenty by fifty feet. Approximately 657 persons went through the blood grouping and typing line and 540 persons had their blood pressures checked. Literature stamped "Courtesy of Florida Medical Association," was distributed to persons passing through the exhibit.

A story about the exhibit or a picture was published at least every other day by the Tallahassee daily newspaper. One radio station broadcast four programs about the showing, beginning two days prior to the fair's opening. Dr. Edson J. Andrews, Tallahassee, was in charge of publicity.

The exhibit was set up for the fair as it was shown during the Florida State Fair in Tampa. There were many compliments on the striking appearance it made among exhibits of farm products from various north Florida counties. A representative of the National Tuberculosis Association from New York City made a sketch of the exhibit because, he said, the idea could be used in his work.

The first two days of the fair were primarily for children. Many of them stopped and exclaimed: "Gee, look at the money!"

Approximately 18,000 persons have seen the exhibit. This total includes both the North Florida Fair and the Florida State Fair.* Of this number, 8,170 have had their blood pressure checked and 4,497 have gone through the blood grouping and typing line.

*Description of the first showing of the exhibit at the State Fair in Tampa was published in the May 1952 Journal.

Korean Casualties

A special press conference was called recently by Maj. Gen. George E. Armstrong, Army Surgeon General, to correct what he said was the public impression that Korean casualties represent "a complete loss to the United States." He reported that at least 85 per cent of United States troops wounded in Korea are being returned to active duty within an average of three months.

General Armstrong placed the total number of this nation's casualties in the neighborhood of 100,000, including 16,500 killed in action, 12,000 missing and 71,500 wounded. Of the wounded, 62,500 have returned to duty, 4,500 remain in Army hospitals, 3,000 have been discharged for disability, and 1,500 have died of wounds.

The death rate of the wounded, 2.4 per cent, is the lowest in any war. General Armstrong attributed this low mortality to rapid evacuation from the front lines and early surgery. He had high praise for newly developed body armor.

Southern Medical Association Forty-Sixth Annual Meeting Miami, November 10-13

For the third time since the organization of the Southern Medical Association in 1906, a Florida doctor will lead the organization this year. Dr. Walter C. Jones of Miami was installed as president of the Association at the Forty-Sixth Annual Meeting in Miami, November 10-13. The other two Florida doctors to hold this office were Dr. James M. Jackson, Miami, 1912, and Dr. H. Marshall Taylor, Jacksonville, 1935. The last annual meeting of the Southern Medical Association held in Florida was in Miami in 1948. The Association had met in Florida three times previously — in Jacksonville in 1912 and in Miami in 1929 and 1946.

Addresses of welcome were delivered at the opening session of the meeting by Dr. Robert B. McIver of Jacksonville, president of the Florida Medical Association, and Dr. Ralph S. Sappenfield of Miami, president of the Dade County Medical Association. Mrs. Richard F. Stover of Miami was installed as president of the Woman's Auxiliary to the Southern Medical Association at a meeting of the Auxiliary.

Members of the Florida Medical Association presenting scientific exhibits during the meeting included: Drs. Leffie M. Carlton, Jr., J. Brown Farrior, Richard A. Bagby and Wesley W. Wilson, Tampa, and Drs. Donald W. Smith, James J. Griffitts, George F. Schmitt, Jr., Benjamin G. Oren, Donald F. Marion, Alfred G. Levin, E. Sterling Nichol, William C. Phillips, Valentine E. Jenkins, Richard E. Strain, Irwin Perlmutter, Carlos P. Lamar, Jack A. McKenzie, Reuben Rochkind, Morton M. Halpern, Maurice Blinski, Bruce M. Hogg, Louis Lemberg and Arthur L. Juers, Miami. Scientific exhibits were also presented by the Florida Medical Association Bureau of Public Relations, the Florida Division of the American Cancer Society and the Dade County Medical Association.

Walter C. Jones, M. D., President
Southern Medical Association

Association members presenting motion pictures were Drs. James R. Nieder, Delray Beach, and Nathaniel M. Levin, Miami.

Dr. Walter W. Sackett, Jr., of Miami, who is vice chairman of the Section on General Practice of the Southern Medical Association, presented a paper and took part in a symposium and panel discussion at meetings of that Section. Papers were presented by Drs. Leonard L. Weil, Miami Beach, and John J. McAndrew, Miami.

At a meeting of the Section on Medicine, Dr. William H. Kelley of Orlando presented a paper.

Dr. Benjamin G. Oren of Miami spoke during a session of the Section on Gastroenterology, and Dr. Lowell S. Selling of Orlando spoke at a session of the Section on Neurology and Psychiatry.

At a meeting of the Section on Pediatrics, case presentations were given by members of the Florida State Pediatric Society, Dr. Lynn W. Whelchel, Miami, presiding. Taking part were Drs. Richard G. Skinner, Jr., Jacksonville; Egbert V. Anderson, Pensacola; Robert F. Mikell, Charles Rosenfeld, John G. Chesney and DeWitt C. Daughtry, Miami; Edgar W. Stephens, Jr., and Lawrence R. Leviton, West Palm Beach; and Charlotte C. Maguire, Orlando.

Papers were presented by Drs. Morris Waisman and Wesley W. Wilson of Tampa at a session of the Section on Dermatology and Syphilology. Drs. Clarence Bernstein, Orlando, and Wiley M. Sams and James H. Putman, Miami, spoke at a meeting of the Section on Allergy, and Dr. Meyer J. Glick of Miami Beach spoke at a session of the Section on Physical Medicine and Rehabilitation.

Speaking at a meeting of the Section on Surgery were Drs. Robert M. Lee, George D. Lilly, Francis N. Cooke and John G. Chesney of Miami. Drs. Eugene L. Jewett, Fred H. Albee, Jr., and Freeman D. Stanford of Orlando, and Herbert W. Virgin, Jr., of Miami spoke at sessions of the Section on Orthopedic and Traumatic Surgery. Drs. S. Joseph Pearlman, Milton M. Coplan, Frank M. Woods, and Perry D. Melvin of Miami; Raymond J. Fitzpatrick, Louis M. Orr, II, and Joseph C. Hayward, Orlando; Russell B. Carson, Fort Lauderdale; Robert B. McIver, William A. Van Nortwick, and Robert J. Brown, Jacksonville; and Edwin W. Brown of West Palm Beach spoke during the meetings of the Section on Urology, and Dr. John J. Cheleden of Ocala spoke at a meeting of the Section on Proctology.

At meetings of the Section on Opthalomology and Otolaryngology, papers were presented by Drs. Richard A. Bagby and J. Brown Farrior, Tampa; Gordon J. McCurdy, Coral Gables; and Robert C. Welsh, Miami. Dr. Stanley H. Axelrod of Miami spoke at a session of the Section on Anesthesiology.

Drs. Lorenzo L. Parks, Clarence M. Sharp, and Wilson T. Sowder of Jacksonville read papers at a meeting of the Section on Public Health, and Dr. Walter E. Murphree, Gainesville, took part in a panel discussion on general practice during a meeting of the Section on Medical Education and Hospital Training.

The American College of Chest Physicians, Southern Chapter, met conjointly with the Southern Medical Association. At a meeting of the College, Drs. DeWitt C. Daughtry and John G. Chesney of Miami presented a paper.

Registration

APALACHICOLA: Photis J. Nichols. **ARCADIA:** Charles H. Kirkpatrick. AVON PARK: Carl J. Larsen. BARTOW: Milo H. Holden. BRADENTON: Lowrie W. Blake, Roderic O. Jones, Millard P. Quillian, William G. Sugg. BUNNELL: John M. Canakaris. CANTONMENT: Stanley G. Childers. COCOA: Thomas C. Kenaston, Charles E. Russell. CORAL GABLES: A. Daniel Amerise, Ira K. Brandt, Clyde Brooks, E. Hampton Bryson, Charles R. Burbacher, Henry H. Caffee, Jack Q. Cleveland, J. Kenneth Cole, Anna A. Darrow, Franklin J. Evans, Richard C. Forman, George R. Gage, Dale L. Groom, Frederick E. Hasty, Glenn H. Heller, Robert P. Keiser, Gordon J. McCurdy, C. Howard McDevitt, Jr., Wesley S. Nock, Frederick P. Poppe, Warren W. Quillian, T. D. Sandberg, Ben J. Sheppard, Merrick D. Thomas, Jr., Rollin D. Thompson, Martiele Turner, Karl W. Vetter, William L. Wagener, Arthur H. Weiland, Hillard W. Willis. DANIA: Fred E. Brammer. DAYTONA BEACH: George P. Beach, Hugh Crawford, C. Robert DeArmas, George M. Green, James D. Moffett, Jr., Achille A. Monaco. DeFUNIAK SPRINGS: William D. Cawthon. DELRAY BEACH: James R. Nieder, Charles A. Robinson. FERNANDINA: Cecil B. Brewton. FORT LAUDERDALE: Norris M. Beasley, Miles J. Bielek, Robert E. Blount, H. Lamar Boese, Oliver C. Brown, Mark Butler, Russell B. Carson, Alfred E. Cronkite, Frank Denniston, Burns A. Dobbins, Jr., Frederick J. Driscoll, Robert L. Elliston, Robert H. Farringer, Roland F. Fisher, Donald H. Gahagen, Walter J. Glenn, Jr., Francis Haberman, Benjamin F. Hart, Anne L. Hendricks, Paul W. Hughes, M. Austin Lovejoy, Richard A. Mills, Claus A. Peterson, George T. F. Rahilly, George M. Rhodes, Jr., Vincent V. Smith, Curtis H. Sory, Frederick P. Swing, Charles L. Wadsworth, William D. Wells, Scottie J. Wilson. FORT MEADE: David H. Varn, Jr. FORT MYERS: William H. Grace, H. Quillian Jones, John S. Stewart. FORT PIERCE: Hugh B. Goodwin, Jr., Laurance D. Van Tilborg, Lester L. Whiddon. GAINESVILLE: Alva T. Cobb, Jr., J. Maxey Dell, Jr., Walter E. Murphree, William C. Thomas, Sr. GREEN COVE SPRINGS: Edwin H. Brown. HIALEAH: Van M. Browne, Eli Galitz, Charles L. Shalloway. HOLLYWOOD: Dale T. Anstine, Louis J. Novak, Frances E. M. Read. HOMESTEAD: Joseph M. Burton. JACKSONVILLE: Sullivan G. Bedell, James L. Borland, Jack H. Bowen, Joseph L. Chilli, William C. Croom, Jr., Joseph A. J. Farrington, A. Judson Graves, Luther W. Holloway, Floyd K. Hurt, Ivan Isaacs, Raymond R. Killinger, Thomas H. Lipscomb, John F. Lovejoy, James G. Lyerly, Charles F. McCrory, William H. McCullagh, John M. McDonald, Robert B. McIver, Charles B. Mabry, Milton C. Maloney, A Sherrod Morrow, Nelson A. Murray, Lorenzo L. Parks, Louis M. Sales, Clarence M. Sharp, Lauren M. Sompayrac, Wilson T. Sowder, G. Dekle Taylor, H. Marshall Taylor, Daniel R. Usdin, William A. Van Nortwick, Stewart Thompson, Edward C. Watt, Donald P. White, Jr., J. Frank Wilson. KEY WEST: Ralph Herz, Allen S. Sheppard. LAKE CITY: Anthony J. Puntereri, Benjamin L. Steinberg. LAKELAND: Jere W. Annis, Chester L. Nayfield, James T. Shelden, Wylie L. Tillis, Herman Watson, S. L. Watson, John W. Williams. LAKE WALES: Joseph L. Kinzie. LAKE WORTH: Carl M. Pults, A. Scott Turk. MARIANNA: Albert E. McQuagge. MELBOURNE: Theodore J. Kaminski, Isabel Roberts. MIAMI: Lawrence Adler, Julius Alexander, Lassar Alexander, Ralph F. Allen, James L. Anderson, Laurin L. Andrews, Edward R. Annis, Roger J. Arango, Samuel Aronovitz, William G. Aten, Jr., Hubert A. Barge,

William J. Barge, Ernest R. Barnett, Ralph E. Baxter, Harry E. Beller, Aaron Bernstein, Morris H. Blau, Maurice Blinski, Valentine Bloch, Abraham Bolker, William K. Boros, David Brezin, John E. Burch, O. Whitmore Burtner, James A. Campbell, Orlon V. Carr, Jr., Bruce D. Carroll, Chester Cassel, Turner E. Cato, Silas E. Chambers, Gail E. Chandler, John G. Chesney, Reuben B. Chrisman, Jr., Richard C. Clay, Francis N. Cooke, Maurice P. Cooper, Milton M. Copeland, Vincent P. Corso, Joseph H. Crawley, Edward W. Cullipher, DeWitt C. Daughtry, David Davidson, Carl H. Davis, H. Clinton Davis, Michael P. DeBoe, John E. Dees, Lydia A. DeVilbiss, Louise DeVore, John W. Dix, Percy L. Dodge, L. Washington Dowlen, Otto S. Dowlen, Adolph E. Drexel, Carl E. Dunaway, Don G. DuPuis, Herbert Eichert, Lee W. Elgin, Wm. H. Ellis, Bruce M. Esplin, Raymond L. Evans, Robert F. Farrington, George Ferre, Nicanor Ferrer, James E. Fischer, Willard L. Fitzgerald, Marvin G. Flannery, Richard M. Fleming, M. Eugene Flipse, M. Jay Flipse, Roger J. Forastiere, Forrest H. Foreman, Edward F. Fox, Bessie S. French, Tom R. Gammage, Edmond Gamse, Hollis F. Garrard, Samuel Gertman, N. Stuart Gilbert, Herman Glassman, Francis W. Glenn, Thomas S. Gowin, J. Raymond Graves, Maurice M. Greenfield, James J. Griffitts, Howard H. Groskloss, Etheridge J. Hall, Morton M. Halpern, Robert M. Harris, Winston F. Harrison, Maurice E. Heck, Ella M. Hediger, Alpha N. Herbert, Andrew H. Hinton, Bruce M. Hogg, James W. Holmes, William M. Howdon, R. Spencer Howell, James J. Hutson, William C. Hutchison, Jack Humphreys, William H. Izlar, Ralph W. Jack, Joseph T. Jana, Jr., Paul S. Jarrett, Leslie M. Jenkins, Edwin J. Jensen, S. Curtis Johnson, Walter C. Jones, Arthur L. Juers, Jack J. Kaufman, Jr., Christian Keedy, Jack Keefe, 3rd, Paul Kells, Alexander I. Kernish, Ralph E. Kirsch, Erna K. Klass, Morris E. Kuckku, Alexander Kushner, Carlos P. Lamar, William T. Lanier, George W. Lawson, Frederick LeDrew, Robert M. Lee, Rothwell Lefholz, Louis Lemberg, Alfred G. Levin, Nathaniel M. Levin, George D. Lilly, Simon M. Lipton, Wm. D. Lithgow, A. Buist Litterer, Joseph Lomax, Manuel C. Lores, Joseph H. Lucinian, John J. McAndrew, Archie McCallister, Jr., George R. McClary, Franklin McElheny, E. Norton McKenzie, George E. McKenzie, Jack A. McKenzie, Wm. W. McKibben, Norman W. McLeod, Jr., John V. McMackin, Plumer J. Manson, Stanley Margoshes, Dominic A. Marion, Donald F. Marion, Isidore Marx, John H. Mason, Jr., Lawrence R. Medoff, Matthias P. Meehan, Perry D. Melvin, James H. Mendel, Sr., Claude G. Mentzer, Hyman Merlin, James W. Merritt, Jr., Robert F. Michael, John D. Milton, Leon H. Mims, Jr., Harry M. Moore, C. Russell Morgan, Jr., R. Sam Mosley, Albert H. Mouradian, S. Robert Nash, Leo Nastasi, David A. Nathan, Elwyn G. Neil, E. Sterling Nichol, Donald H. Nixon, Russell K. Nuzum, Benjamin G. Oren, Samuel W. Page, Jr., Frazier J. Payton, S. Joseph Pearlman, Colquitt Pearson, Homer L. Pearson, Jr., Eduardo F. Pena, Max Pepper, Irwin Perlmutter, Kenneth Phillips, Roland F. Phillips, William C. Phillips, Benjamin G. Pollock, Edwin P. Preston, James H. Putman, John R. Ramey, Harold Rand, Jack O. W. Rash, Homer A. Reese, W. Carlton Rentz, Jr., Maurice Rich, John R. Richardson, Julian A. Rickles, Samuel J. Roberts, George W. Robertson, Julian Robinson, Reuben Rochkind, Hunter B. Rogers, Charles Rosenfeld, Manning, J. Rosnick, Bernard D. Ross, Ruth W. Rumsey, Lyle W. Russell, Thomas N. Ryon, Walter W. Sackett, Jr., S. Marion Salley, Wylie M. Sams, Milton S. Saslaw, Chaffee A. Scarborough, Oden A. Schaeffer, Peritz Scheinberg, George F. Schmitt, Jr., Manuel A. Schofman, John M. Schultz, Joseph W. Scott, E. Clay Shaw, C. Kirby Smith, Donald W. Smith, Federico A. Smith, James H. Smith, Marvin H. Smith, John W. Snyder, John A. Speropoulus, Robert T. Spicer, Donald G. Stannus, William Steinman, Irvin Stemmerman, Franz H. Stewart, Joseph S. Stewart, Richard F. Stover, Richard E. Strain, Kelly C. Thomas, Henry L. Tippins, Herbert W. Virgin, Jr., Ferdinand A. Vogt, Harrison A. Walker, Preston H. Watters, Isaac N. Weinkle, Robert C. Welsh, Lynn W. Whelchel, William Wickman, Edward H. Williams, George Williams, Jr., Louis J. Wisch, Arthur W. Wood, Jr., Frank M. Woods, Leo S. Wool, Jack L. Wright, Corren P. Youmans, Iva C. Youmans, Leo A. Zuckerman. MIAMI BEACH: Mortimer D. Abrashkin, Irving L. Alberts, Harold P. Auslander, Bernard Baer, Theodore M. Berman, Herman Boughton, Judd R. Breakstone, Raymond Breitbart, Lewis Capland, Max Dobrin, Rudolph E. Drosd, Maurice I. Edelman, Howard A. Engle, David W. Exley, Jack J. Falk, Henry Feintuch, I. Leo Fishbein, Emmett Fitzpatrick, Stanley Frehling, Elias Freidus, Meyer J. Glick, Milton S. Goldman, Bernard Goodman, Max Gratz, Harrien W. Gray, Robert J. Grayson, Irvin M. Greene, Leo Grossman, Hugh H. Hawley, Hugh H. Hawley, Jr., Abraham R. Hollender, Leonard H. Jacobson, Valentine E. Jenkins, Lewis L. Julien, Samuel Kaplan, Saul H. Kaplan, Bernard S. Kleinman, Samuel B. Kleinman, Maurice Kovnat, Harry Kraff, Andrew J. Leon, George N. Leonard, Morris J. Levine, Alexander Libow, David S. Light, Charles Lippow, Rose E. P. London, Seymour B. London, Leon H. Manheimer, Meyer B. Marks, Edward W. Mencher, Saul Miller, Lewis Palay, Cayetano Panettiere, Julius R. Pearson, Jean J. Perdue, Joseph B. Pomerance, Robert J. Poppiti, George L. Rand, Francis A. Reed, Paul S. Roland, Maurice J. Rose, Alexander E. Rosenberg, Robert R. Rosenblum, Edward Roth, Leonard G. Rowntree, Jack A. Rudolph, Charles A. Schwarz, Jandon Schwarz, Sol Selevan, Morris N. Silverberg, John H. Tanous, Earl R. Templeton, Efton J. Thomas, Rene A. Torrado, M. P. Travers, Harold D. Van Schaick, Leonard L. Weil, Barney Weinkle, D. Ward White, Maurice Zimmerman, Nelson Zivitz. MIAMI SHORES: Carl M. Midkiff, Stanley J. Plucinski. MIAMI SPRINGS: Estella G. Norman, Louis C. Pessolano. MOUNT DORA: Sanford C. Colley. NEW SMYRNA BEACH: William C. Chowning. NORTH MIAMI Ludwig M. Ungaro, Charlotte K. Wilkins. OCALA: John J. Cheleden. ORLANDO: Fred H. Albee, Jr., Clarence Bernstein, Benjamin M. Cole, Chas. J. Collins, John E. Crews, Horace A. Day, Elwyn Evans, Raymond J. Fitzpatrick, Truett H. Frazier, L. Paul Foster, George W. Griffin, Joseph L. Hundley, Eugene L. Jewett, Harold W. Johnston, William H. Kelley, Morton Levy, Morris H. R. Lukens, Charlotte C. Maguire, Meredith Mallory, Sr., J. William Martin, Duncan T. McEwan, Lowell S. Selling, Joseph G. Seltzer, Philip F. Simensky, Joseph L. Stecher, W. Dean Steward. PAHOKEE: Emil J. Graham, Ernest C. Johnson, Jr. PALM BEACH: Edwin D. Davis, Russell D. D. Hoover, Walter G. Robinson, Bailey B. Sory, Jr. PALMETTO: John L. Jennings, Jr. PENSACOLA: John J. McGuire, Rosa L. Sullivay, Frank E. Tugwell. QUINCY: Julius C. Davis. RIVIERA: Frank M. Hewson, Jr. ST. AUGUSTINE: Redden Britt, Hardgrove S. Norris. ST. PETERSBURG: Harry L. Allan, Jr., Charles E. Aucremann, John H. Cordes, Jr., Harry R. Cushman, Albert R. Frederick, Abraham J. Gorde, Dean W. Hart, Frederick C. Knight, Irwin S. Leinbach, Robert C. Lonergan, Kenneth J. Weiler, Ruth Winston. SARASOTA: Eugene D. Liddy, Jr., Sherrel D. Patton, Hugh G. Reaves, Reaves A. Wilson. SOUTH MIAMI: Robert V. Edwards, James H. Mendel, Jr., James A. Vaughn, Jr., Franklyn E. Verdon. STUART:: Walter F. Davey. TALLAHASSEE: Odis G. Kendrick, Jr., John A. Lauer, Jr., Henry L. Smith, Jr. TAMPA: Chadbourne A. Andrews, Richard A. Bagby, Chas. W. Bartlett, Harold O. Brown, Leffie M. Carlton, Jr., Edith M. Corlew, Elsie M. Gilbert, Chas. McC. Gray, Samuel G. Hibbs, Paul J. McCloskey, Thomas E. McKell, Neal J. Phillips, Roy F. Saxon, Hawley H. Seiler, Edward F. Shaver, Marshall E. Smith, Wray D. Storey, Morris Waisman, J. Maxwell Williams, Jr., Frances C. Wilson, Wesley W. Wilson. VENICE: Samuel E. Kaplan, Talmadge S. Thompson. VERO BEACH: John P. Gifford, Erasmus B. Hardee, James C. Robertson. WEST MIAMI: Bernard Yesner. WEST PALM BEACH: Willard F. Ande, James R. Anderson, Robert V. Artola, Burton F. Barney, Edwin W. Brown, C. Jennings Derrick, W. Wellington George, Charles McD. Harris, Jr., Frederick K. Herpel, W. Ambrose McGee, Walter R. New-

bern, David A. Newman, Theodore Norley, William H. Proctor, Herman G. Rose, James R. Sory, Laurie R. Teasdale. WILLISTON: Clifford E. Vinson. WINTER HAVEN: Newell J. Griffith. WINTER PARK: George R. Crisler, Ruth S. Jewett.

Medical District Meetings 1952

The first meeting this year was held in Panama City, October 27, followed by St. Petersburg, October 29, Fort Pierce, October 30, and Daytona Beach, October 31. The officers of your Association and the Chairman of the Council donated their time and expenses for the week and traveled a circuit which is more than 900 miles starting from Jacksonville. This is just another evidence of effort on the part of your leaders to bring to the members information concerning Association affairs.

It is impossible for your president to make individual trips throughout the state to visit the majority of the county medical societies and groups of members during one year. It is also impossible for the majority of our 2,348 members to visit the headquarters office in Jacksonville frequently. With this in mind, the annual medical district meetings were instituted as the medium through which a great many members could contact the president and other officers in order to strengthen the activities of the Association being promoted, and plan for efficiency and enlargement.

Large registration is not expected at every medical district meeting, as there is only one-half day and evening in the schedule. However, those who attended were enthusiastic in their favorable comments and the officers of the Association expressed themselves as being well repaid by meeting new colleagues and renewing the acquaintance of old ones.

The Woman's Auxiliary to the Florida Medical Association, under the leadership of Mrs. Herschel G. Cole, president, arranged work-shop meetings for the ladies during the afternoon and joined the doctors for the dinner and evening session on legislation.

Northwest Medical District

October 27 — Panama City

President Robert B. McIver headed a group of Association officers and committee chairman who presented short talks at the late afternoon general session. Presiding was Dr. Eugene G. Peek, Jr., Chairman of Council, assisted by Dr. Francis M. Watson, councilor of District 1.

In addition to Dr. McIver, who spoke on activities in connection with the Association's annual meeting, present were: Dr. Samuel M. Day, Secretary-Treasurer; Dr. Shaler Richardson, Editor of The Journal; and Dr. J. Rocher Chappell, Chairman, Advisory to Selective Service Committee.

The evening session following dinner was in charge of Dr. J. Phillip Hampton, Chairman, Committee on Legislation and Public Policy. Woman's Auxiliary members and guests were in attendance.

Dr. Charles H. Daffin, President, Bay County Medical Society, welcomed visiting officials and guests as this Thirteenth Annual Medical District Meeting was called to order at 2:30 p.m.

Immediately following the address of welcome, and prior to the talks by Association officers, scientific papers were presented by Drs. Merritt R. Clements of Tallahassee and Hawley H. Seiler (by invitation) of Tampa. Dr. Clements spoke on "A Phase of Postpartum Bleeding with Case Reports," and Dr. Seiler's subject was "Thoracic Problems of Interest to the General Practitioner."

The 1953 meeting will be in Tallahassee. Total registration was 64, of which 39 were Association members (A District 30), 5 visitors and 20 Woman's Auxiliary members. Among those registered were Past Presidents Julius C. Davis and Shaler Richardson.

Registration

APALACHICOLA: Photis J. Nichols. GRACEVILLE: Redden L. Miller. JACKSONVILLE: Samuel M. Day, Robert B. McIver, Shaler Richardson, Stewart Thompson, Wilson T. Sowder. MARIANNA: James T. Cook, Jr., Albert E. McQuagge, Francis M. Watson. OCALA: Eugene G. Peek, Jr. ORLANDO: J. Rocher Chappell. PANAMA CITY: J. Powell Adams, John J. Benton, Jack Corbitt, Charles H. Daffin, Sidney E. Daffin, William F. Humphreys, Jr., John H. Kay, Michael J. Lingo, Joseph H. Morris, James M. Nixon, Martle F. Parker, James A. Poyner, William C. Roberts, C. W. Shackelford, Harold E. Wager, G. Ashby Winstead. PENSACOLA: William P. Hixon, John C. McSween, Jr. PORT ST. JOE: Albert L. Ward. QUINCY: Julius C. Davis, Taylor W. Griffin. TALLAHASSEE: Merritt R. Clements, Francis T. Holland, Henry L. Smith, Jr. TAMPA: H. Phillip Hampton, Hawley H. Seiler. WEWAHITCHKA: Harold B. Canning.

VISITING DOCTORS — PANAMA CITY: Daniel C. Campbell, William C. Fontaine, Andres G. Oliver.

OTHER GUESTS — JACKSONVILLE: W. Harold Parham. TALLAHASSEE: Tom Stallworth.

Southwest Medical District

October 29 — St. Petersburg

President Robert B. McIver and a group of Association officers and committee chairmen were present at the meeting and gave short talks at the late afternoon general session. Presiding was Dr.

Eugene G. Peek, Jr., Chairman of Council, who was assisted by Dr. Hugh G. Reaves, councilor of District 5.

Dr. McIver spoke on activities in connection with the Association's annual meeting. Also present were Dr. Samuel M. Day, Secretary-Treasurer; and Dr. J. Rocher Chappell, Chairman, Advisory to Selective Service Committee. Dr. Francis H. Langley, First Vice President, and Dr. Eugene B. Maxwell, Chairman, Committee on Public Relations, were recognized.

Dr. H. Phillip Hampton, Chairman, Committee on Legislation and Public Policy, was in charge of the evening session following dinner. Woman's Auxiliary members and guests were present.

Dr. Clyde O. Anderson, First Vice President, Pinellas County Medical Society, welcomed visiting officials and guests at 2:30 p.m. when this Thirteenth Annual Medical District Meeting was called to order.

Following the address of welcome, and before the talks made by Association officers, scientific papers were presented. Dr. Leffie M. Carlton, Jr., of Tampa spoke on "Management of Thoracic Problems in General Practice," and Dr. Melvin M. Simmons of Sarasota spoke on "The Female Urethra in the Diagnosis of Abdominal and Pelvic Pain." Dr. Emmett E. Martin, councilor of District 6, presided with Dr. Peek at this session.

Tampa will be the site of the 1953 meeting. Total registration was 115, of which 69 were Association members (C District 64), 7 visitors and 39 Woman's Auxiliary members. Past Presidents of the Florida Medical Association in attendance included David R. Murphey, Jr., and Shaler Richardson.

Registration

BRADENTON: Willis W. Harris, Millard P. Quillian. CLEARWATER: Francis C. Hoare, John T. Karaphillis, James M. Stem. DUNEDIN: Walter H. Winchester. FORT MYERS: Harry Fagan, Jr., William H. Grace, H. Quillian Jones, Joseph L. Selden, Jr. HAINES CITY: Emmett E. Martin. JACKSONVILLE: Samuel M. Day, Robert B. McIver, Stewart Thompson, Wilson T. Sowder. LAKELAND: Wylie L. Tillis. OCALA: Eugene G. Peek, Jr. ORLANDO: J. Rocher Chappell. PALMETTO: John L. Jennings, Jr. ST. PETERSBURG: Clyde O. Anderson, Arthur J. Bieker, William M. Davis, Reid E. Dicks, Luverne H. Domeier, Chas. L. Farrington, N. Worth Gable, Abraham J. Gorday, James L. Gouaux, George F. Hieber, William E. Kendall, Peter B. Kersker, Frederick C. Knight, Roscoe H. Knowlton, E. Ransom Koontz, Francis H. Langley, Whitman C. McConnell, Whitman H. McConnell, Norval M. Marr, Alvin L. Mills, John B. O'Neill, R. Wynn S. Owen, Harrison G. Palmer, John P. Rowell, Roderick C. Webb, Carl A. Williams. SARASOTA: J. Edward Harris, Robert O. Pitts, Hugh G. Reaves, Melvin M. Simmons, Reaves A. Wilson. SEBRING: Zaven M. Seron. TAMPA: Efrain C. Azmitia, C. MacKenzie Brown, Harold O. Brown, Leffie M. Carlton, Jr., Frank V. Chappell, Herschel G. Cole, John D. Flynn, H. Phillip Hampton, Alfonso F. Massaro, Eugene B. Maxwell, David R. Murphey, Jr., Lee T. Rector, Hawley W. Seiler, Lynwood B. Smith, Marshall E. Smith, Mason Trupp, Wesley W. Wilson. VENICE: Samuel E. Kaplan.

VISITING DOCTORS — CLEARWATER: George F. Grisinger, Jr. GULFPORT: George H. Koenig. JACKSONVILLE: Ralph W. McComas. ST. PETERSBURG: Rodes C. Garby. SARASOTA: Lloyd J. Duest. OHIO — CLEVELAND: Robert A. Harvey.

OTHER GUESTS — JACKSONVILLE: W. Harold Parham.

Southeast Medical District

October 30 — Fort Pierce

President Robert B. McIver and a group of other Association officers and committee chairmen presented short talks at the late afternoon session. Dr. Eugene G. Peek, Jr., Chairman of Council, and Dr. Donald W. Smith, councilor of District 8, presided.

Dr. McIver spoke on activities in connection with the Association's annual meeting. Other officers in attendance were: Dr. Frederick K. Herpel, President-Elect; Dr. Samuel M. Day, Secretary-Treasurer; Dr. Webster Merritt, Assistant Editor of The Journal; and Dr. J. Rocher Chappell, Chairman, Committee on Advisory to Selective Service for Physicians and Allied Specialists.

The evening session following dinner was in charge of Dr. H. Phillip Hampton, Chairman, Committee on Legislation and Public Policy. Woman's Auxiliary members and guests also attended.

Dr. Richard F. Sinnott, President, St. Lucie-Okeechobee-Martin County Medical Society, welcomed visiting officials and guests to this Thirteenth Annual Medical District Meeting as it was called to order at 2:30 p.m.

Immediately following the address of welcome, and prior to the talks given by Association officers, the scientific assembly was held. Presiding were Dr. Eugene G. Peek, Jr., Chairman of Council, and Dr. Erasmus B. Hardee, councilor of District 7. Dr. Sidney Davidson of Lake Worth spoke on "Diabetic Neuropathy," and Dr. Richard M. Fleming of Miami spoke on "The Early Diagnosis and Management of the Common Neoplasms."

The 1953 meeting will be held in West Palm Beach. Total registration was 76, of which 49 were Association members (D District 42), 7 visitors and 20 Woman's Auxiliary members. A Past President of the Association in attendance was Joseph S. Stewart.

Registration

CORAL GABLES: Anna A. Darrow, Jerome A. Megna. DANIA: Fred E. Brammer. DELRAY BEACH: Graham W. King, Jr. FORT LAUDERDALE: Burns A. Dobbins, Jr., William A. Exum, Scottie J. Wilson. FORT PIERCE: Russell L. Counts, Hugh B. Goodwin, Jr., Francis A. Gowdy, Steve R. Johnston, John T. McDermid, Jack H. Robbins, Adrian M. Sample, Richard F. Sinnott, Laurance D. Van Tilborg, Lester L. Whiddon. JACKSONVILLE: Samuel M. Day, Robert B. McIver, Webster Merritt, Stewart Thompson, Wilson T. Sowder. LAKE WORTH: Sidney Davidson. MIAMI: Reuben B. Chrisman, Jr., Richard M. Fleming, Paul S. Jarrett, John D. Milton, Donald W. Smith, Joseph S. Stewart. OCALA: Eugene G. Peek, Jr. OKEECHOBEE: Leon S. Eisenman. ORLANDO: J. Rocher Chappell. STUART: Julian D. Parker. TAMPA: H. Phillip Hampton. VERO BEACH: John P. Gifford, Erasmus B. Hardee, James C. Robertson. WEST PALM BEACH: James R. Anderson, Horace D. Atkinson, Edwin W. Brown, Charles McD. Harris, Jr., Frederick K. Herpel, Richard M. Irwin, W. Ambrose McGee, Lloyd J. Netto, Theodore Norley, Ralph M. Overstreet, Jr., Atwell B. Pride (Col.), Raymond S. Roy.

VISITING DOCTORS — FORT PIERCE: Alfred J. Cornille. JACKSONVILLE: Ralph W. McComas. MIAMI: Claude D. Holmes, Jr. VERO BEACH: John E. Burt, Briant B. Guerin, Leo Sheiber.

OTHER GUESTS — JACKSONVILLE: W. Harold Parham.

Northeast Medical District

October 31 — Daytona Beach

President Robert B. McIver headed a group of Association officers and committee chairmen who presented short talks at the late afternoon general session. Dr. Eugene G. Peek, Jr., Chairman of Council, and Dr. William C. Thomas, Jr., councilor of District 3, presided at the sessions.

Dr. McIver spoke on activities in connection with the Association's annual meeting. Officers present in addition to Dr. McIver included: Dr. Frederick K. Herpel, President-Elect; Dr. Samuel M. Day, Secretary-Treasurer; Dr. Webster Merritt, Assistant Editor of The Journal; and Dr. J. Rocher Chappell, Chairman, Advisory to Selective Service Committee.

Dr. J. Richard West, President, Volusia County Medical Society, welcomed visiting officials and guests as this Thirteenth Annual Medical District Meeting was called to order at 2:30 p.m.

The scientific assembly was held immediately following the address of welcome and prior to the talks by Association officers. Dr. Edward P. Madden of Daytona Beach spoke on "Problems in Sterility," and Dr. Norman E. Williams of Daytona Beach spoke on "Management of the Ambulatory Cardiac."

St. Augustine was chosen as the 1953 meeting place. Total registration was 85, of which 60 were Association members (B District 58), 5 visitors and 20 Woman's Auxiliary members. Among those registered was Past President William C. Thomas, Sr.

Registration

BUNNELL: John M. Canakaris. DAYTONA BEACH: Charles A. Brown, John J. Cheleden, James W. Clower, Jr., C. Robert DeArmas, George M. Green, Carroll V. Herron, Robert D. Higgins, William L. Jennings, Herbert A. King, Eric H. Lenholt, George H. McSwain, Edward P. Madden, James D. Moffett, Jr., Ruth T. Rogers, Joseph H. Rutter, Lawrence J. Schneider, Ellsworth F. Waite, J. Richard West, Norman E. Williams, Charles J. Wolfe. DELAND: Lancaster C. Starke (Col.). GAINESVILLE: William C. Thomas, Sr., William C. Thomas, Jr., HOLLY HILL: Frank A. Sica. JACKSONVILLE: Cornelius A. Bird, James L. Borland, Samuel M. Day, Lawrence E. Geeslin, James G. Lyerly, Robert B. McIver, Webster Merritt, Thaddeus M. Moseley, Nelson A. Murray, Joseph H. St. John, John T. Stage, Stewart Thompson, Wilson T. Sowder. LEESBURG: George E. Engelhard. MIAMI: John D. Milton. MOUNT DORA: Sanford C. Colley. OCALA: William H. Anderson, Jr., Hugh H. Barfield, Carl S. Lytle, Eugene G. Peek, Jr. ORLANDO: J. Rocher Chappell, Chas. J. Collins, James G. Economon, James B. Glanton, Eugene L. Jewett, Duncan T. McEwan, Robert G. Neill, Louis E. Pohlman, W. Dean Steward. PALATKA: Grover C. Collins. SANFORD: J. Clifford Boyce, Thomas F. McDaniel, Harry Z. Silsby, George H. Starke (Col.). WEST PALM BEACH: Frederick K. Herpel.

VISITING DOCTORS — JACKSONVILLE: Joseph W. Eversole, Ralph W. McComas. PONTE VEDRA BEACH: Simon D. Doff.

OTHER GUESTS — JACKSONVILLE: W. Harold Parham.

CORRESPONDENCE

Editor's Note — The following communications are published in this column by request and with the approval of both parties.

Explanation—Annual Registration with State Board of Health

Florida State Board of Health
Tallahassee, Florida

Dear Sirs:

I would like to ask why the doctors of Florida are compelled to spend $1.00 annually for a registration certificate, when we have to pay $1.00 annually for a narcotic license and also have to register in the county courthouse where we practice. The data is there to be seen at any time by any body.

It seems to me that this tax is absolutely unnecessary and I am expecting an explanation from you as to its purpose. We have got to cut out waste somewhere and this is a good place to begin.

Yours truly,

(Signed) Marvin Smith, M.D.

Miami, Florida
October 4, 1952

Marvin Smith, M.D.
800 S. W. Nineteenth Avenue
Miami 35, Florida

Dear Doctor Smith:

In answer to your letter of October 4, 1952, forwarded to me from Tallahassee, beg to advise that the Physicians' Registration Act was sponsored by the Florida Medical Association of which, I notice, you are a life member. It was passed by the legislature of 1927 and was then known as Chapter 12005, Laws of Florida. This Chapter is now known as 458.06, Florida Statutes 1951, subsections (2) through (6) dealing with this particular phase of the law. This Act requires all practitioners of the healing arts to register with the State Board of Health on or before January first of each and every year and to pay at such time a fee of one dollar. The Medical Association's purpose in bringing about the passage of this Act was to combat a license and diploma mill which existed at such time and was flooding Florida with fraudulent medical diplomas and licenses.

Prior to 1921, there existed in the State of Florida three medical examining boards; namely, State Board of Medical Examiners, State Board of Eclectic Medical Examiners and State Board of Homeopathic Medical Examiners. An Act was passed in 1921 which combined these three boards under one composite board consisting of medical doctors, eclectic and homeopathic physicians and was known as the State Board of Medical Examiners.

After the repeal of the act which created the State Board of Eclectic Medical Examiners, it was found that the Eclectic Board's secretary was continuing to issue eclectic medical licenses and diplomas for a sum of money to persons who had never attended a medical school. Dozens of these licenses were issued and some are even in use in Florida to this day. It was through the use of this Physicians' Registration Act that the diploma mill operator was apprehended and the mill broken up. I will, however, begin with the year 1941 since this is the year that the Physicians' Registration Act was transferred from the Bureau of Vital Statistics to the Bureau of Narcotics. The transfer of these duties was brought about by Herbert L. Bryans, M.D., President of the State Board of Health, who was of the opinion that the Physicians' Registration Act along with the enforcement of the medical laws should be under a bureau vested with investigative and police powers.

The first official act of this Bureau was to conduct an investigation of the diploma and license mill operating in Florida at such time. After more than a year of criminal investigative work in co-operation with William M. Rowlett, M.D., then Secretary of the State Board of Medical Examiners, and the postal authorities, the head of this diploma mill, a physician, an attorney and two other diploma mill graduates were arrested, convicted and sentenced to prison terms. The head of this diploma mill died in prison thus bringing to an end a disgraceful situation in the State of Florida.

During the Bureau of Narcotics' first year's activities, in addition to the above-mentioned cases, twenty-four persons were arrested and convicted for practicing medicine in Florida without a license. In one particular case a person had stolen the license and diploma of a legitimate practitioner who had died in Kentucky, assumed his name and was carrying on a lucrative practice. This imposter posted a bond and skipped out before his trial came up but was later apprehended in another state by an agent of this Bureau, returned to Florida, tried, convicted and sentenced to five years in the State Prison. In addition to the above, I set forth herewith a partial report of the activities of this Bureau for the past eleven years with reference to the Medical Practice Act.

MEDICAL PRACTICE ACT

Total number of arrests	112
Aggregate sentences imposed	59 yrs., 4 mo., 8 days
Aggregate fines imposed	$8,538.08
Criminal injunctions granted by the courts	8

Since receiving your letter of October 4, there have been two arrests for practicing medicine without a license; one being sentenced to five years and the other awaiting sentence at this time. This is made possible by the registration of thirty-nine hundred medical doctors yearly; the price of two good cigars to each physician.

I believe that if you will check the records of the State Board of Medical Examiners, you will find that the Bureau of Narcotics has arrested and brought to justice more violators of the Medical Practice Act in any one year than was obtained by the State Board of Medical Examiners from 1889 to 1941 combined. This is no criticism

of the State Board of Medical Examiners as they had no funds and no investigators.

The above activities are in addition to our regular duties of enforcing the narcotic laws.

If, after reading the above explanation of the Registration Act, and the purposes of the $1.00 fee, you still feel that the expenditure is a waste, I would suggest that you communicate with the Florida Medical Association, who sponsored passage of the act.

Yours truly,
(Signed) M. H. Doss
Director, Bureau of Narcotics
Florida State Board of Health

Jacksonville, Florida
November 13, 1952

STATE BOARD OF HEALTH

The Reporting of Communicable Diseases

The County Health Departments are responsible for the control of communicable diseases in each of their counties. In order for these health departments to render control measures it is necessary for them to be informed of what diseases are occurring, where they are occurring and under what circumstances. The physician in private practice plays an important role in the control of communicable diseases. He is the first person to diagnose or suspect a communicable disease.

Improvements in sanitation and the use of newer antibiotics have made many of the communicable diseases of less danger to the public health than they were a few years ago. Some communicable diseases are still occurring in Florida, however, and it is believed that these are of sufficient importance to warrant continuous study. There are occasional outbreaks of food poisoning and epidemics of respiratory diseases. Much factual material is being gathered regarding the role of insects in the transmission of disease. The relationship between certain types of mosquitoes and encephalomyelitis probably will be better understood in the near future as will other presently unsolved problems.

It is the desire of the Public Health workers that the physicians make known to them cases of communicable diseases, and special information is desired in regard to the following items:

All cases, or suspected cases, of smallpox, anthrax, botulism, psittacosis, plague, and rabies in man.

Typhoid fever following a gathering such as a dinner or picnic, when one or more cases occur in which the milk or water water supply has been proved or suspected of being the vehicle of infection, or two or more cases having, or presumed to have, a common source.

All outbreaks in which water or food (including milk, milk products, and shellfish) are found to be, or are suspected of being, the vehicle of infection, regardless of etiology.

All outbreaks of diarrhea of the newborn occurring in hospitals or institutions.

All outbreaks occurring in institutions (hospitals, boarding schools, orphanages, summer camps, etcetera) regardless of their etiology.

Multiple cases of undiagnosed disease, especially when they occur in industrial groups.

High incidence of respiratory diseases, particularly during periods when influenza is likely to occur.

Unusual occurrence of anthrax, psittacosis, plague, equine and St. Louis types of encephalomyelitis, and leptospirosis, in animals, since these diseases may spread to man.

Multiple cases or groups of cases of a disease occurring under unusual circumstances such as an uncommon mode of spread, a relatively high case-fatality rate, and a high incidence of disease "out of season."

Medical Officers Returned

Dr. Arthur J. Henry, Jr., who entered military service on Oct. 26, 1950, was released from active duty on Oct. 31, 1952 with the rank of Lieutenant (USNR). His address is 515 N. Adams St., Tallahassee.

STATE NEWS ITEMS

The Committee on Medical Motion Pictures of the A. M. A. has announced the publication of a new revised film list which includes 78 medical films not readily available from other sources. This list is available from the Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn St., Chicago 10.

Dr. Luther W. Holloway of Jacksonville was honored recently at a banquet during the Seventeenth Annual Fall Meeting of the Florida Pediatric Society in West Palm Beach. The Convention was dedicated to Dr. Holloway as a leader in Florida in the pediatric field.

Dr. Courtlandt D. Berry of Orlando spoke on "Life and Experiences in Puerto Rico" at a recent supper meeting of the Men's Club of St. Michael's Episcopal Church in Orlando.

Dr. Vernon T. Grizzard, Jr., of Jacksonville attended the annual meeting of the Congress of Neurological Surgeons at the Palmer House, Nov. 6-8, 1952.

Drs. Franklin W. Roush, Jr., and Woodrow B. Estes of St. Petersburg have recently returned from a trip through England and the European continent. At the request of Dr. J. Hillis Miller, president of the University of Florida, the two doctors made an investigation and brought home information on hospitals, hospital management and medical schools in the countries they visited.

Dr. Frank S. Whitman of West Palm Beach was installed as president of the Association of Seaboard Air Line Railway Surgeons at its Fiftieth Annual Session in Miami, Nov. 18-20, 1952.

Dr. Thomas G. Simmons of Auburndale was chosen "Man of the Year" by the Auburndale Chamber of Commerce at its annual banquet in November.

Dr. Marvin G. Flannery of Miami spoke to members of the Miami Acacia Club on "Surgical Aspects of Medicine" at a recent meeting of the group at the McAllister Hotel.

Dr. Joel V. McCall, Jr., of Daytona Beach took part in a panel discussion on "Building Healthy Personalities" at a recent meeting of the Ormond P.-T.A.

Dr. Chester Cassel of Miami attended the postgraduate course in gastroenterology at the University of Pennsylvania, which was held under the auspices of the American College of Physicians, December 1-7.

Dr. John W. Snyder of Miami spoke on "Surgery in the Aged" at the meeting of the Association of Seaboard Air Line Railway Surgeons in Miami in November.

Dr. Charles H. Ryals of Grand Ridge has been chosen by the Woodmen of the World as the outstanding citizen of the year in that vicinity and was given the "Outstanding Citizen Award" during a special program on November 23. The day was designated as "Dr. Ryals Day." At the age of 77, Dr. Ryals is still active in his practice in which he has been engaged at Dellwood for the past 50 years.

Dr. Samuel M. Day of Jacksonville was one of the speakers at the Fiftieth Annual Meeting of the Association of Seaboard Air Line Railway Surgeons in Miami, Nov. 18-20, 1952. His subject was "Tuberculosis of the Lumbar Spine."

Dr. Carlos P. Lamar of Miami spoke on the modern treatment of Diabetes Mellitus at the Conference on Endocrinology and Metabolism in Havana, Cuba, November 13 and 14.

Dr. Frederick H. Bowen of Jacksonville spoke on "Surgery of the Hand" at the Fiftieth Annual Meeting of the Association of Seaboard Air Line Railway Surgeons in Miami in November.

Dr. Jack Q. Cleveland of Coral Gables, Chairman of the Association's Committee on Medical Education and Hospitals, will represent Florida at a meeting to open the 1953 drive of the American Medical Education Foundation, at the Sheraton Hotel, Chicago, on January 25.

Drs. John P. Turk, Jr., George E. McKenzie, Maurice M. Greenfield, Allan K. Michaelson and John G. Chesney of Miami, Raymond Breitbart of Miami Beach, and Dale L. Groom and Gordon J. McCurdy of Coral Gables have recently appeared on the Dade County Medical Association's daily radio program, "Tell Me, Doctor."

Dr. Chas. W. Bartlett of Tampa has been appointed a member of the State Board of Medical Examiners. The appointment was made in November by Governor Warren.

Dr. Robert W. Ferguson of Tampa, who has been taking special training at Grady Memorial Hospital in Atlanta for the past 18 months, will remain there continuing his studies for another year.

Dr. Jere W. Annis of Lakeland, President of the Florida Heart Association, spoke at an open board meeting of the Palm Beach County Heart Association at Good Samaritan Hospital in November. He spoke on heart disease and the importance of education in the cardiovascular field. The meeting commemorated the first birthday of the Palm Beach County Association.

Dr. Turner Z. Cason of Jacksonville recently spoke on obesity at a meeting of the Jacksonville Exchange Club. As proof of the number of people who need to overcome obesity, a portable scale was used to weigh the members as they arrived at the meeting.

Dr. Ashbel C. Williams of Jacksonville spoke at a recent joint meeting of the Rotary, Kiwanis, Lions and Exchange Clubs of Hollywood. Dr. Williams, who is president of the Florida Division of the American Cancer Society, spoke on "Cancer, The Problem and Where We Stand."

Dr. Jack Q. Cleveland of Coral Gables spoke on first aid and medical problems at a recent meeting of the Exchange Club of Northeast Miami.

Dr. Gary E. Turner of Jacksonville spoke on "Happiness" at the monthly meeting of the Beta Sigma Phi in October.

Drs. William J. Knauer, Jr., Samuel R. Lamb, and Irvin C. Schneider of Jacksonville have been called into active duty with the armed forces.

Drs. Lorenzo L. Parks and Wilson T. Sowder of Jacksonville were delegates from Florida to help organize an American Academy of Preventive Medicine in Cleveland in October.

Dr. Arthur J. Butt of Pensacola recently presented lectures sponsored by the Mayo Clinic and Mayo Foundation for Medical Education and Research at Rochester, Minn. His subject was "Urine as a Continuation of the Extracellular Ground Substance."

Dr. M. Eugene Flipse of Miami has returned to his practice associated with Dr. M. Jay Flipse, following postgraduate study at the Mayo Clinic. Dr. Flipse spent three years in Medical Fellowship at the Clinic and six months residency in Nopeming Sanatorium, Nopeming, Minn. He has been certified by the American Board of Internal Medicine in Internal Medicine and in the subspecialty of Pulmonary Diseases. His practice will be limited to Internal Medicine and Bronchoscopy.

Dr. Frank D. Gray of Orlando was recently elected president of the Orlando Chamber of Commerce.

Dr. Laurie J. Arnold, Jr., of Lake City has been elected as one of the directors at large of the State Board of Directors of the Florida Division of the American Cancer Society, and Dr. Thomas H. Bates, also of Lake City, has been elected Medical Delegate Director representing District No. 4.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Ferdinand H. Kauders of Miami announce the birth of a son, Michael Robin, on Oct. 19, 1952.

Dr. and Mrs. Theodore R. Stevens of Miami announce the birth of a daughter, Carol Ann, on Nov. 2, 1952.

Deaths — Members

Clemmer, Charles A., Ormond Beach	Nov. 3, 1952
Early, Charles S., Lakeland	Nov. 20, 1952
Winchester, Harold E., Dunedin	Nov. 29, 1952
Spiers, W. Henry, West Palm Beach	Dec. 8, 1952

Deaths — Other Doctors

Meyers, Max I., Columbia, Pa.	June 14, 1952
Woods, E. Bryant, Atlanta, Ga.	Nov. 7, 1952
Gauzza, Valentine P., Miami Beach	Nov. 27, 1952

Errata

The death of Dr. Flavius G. Pernoud, Jr., St. Louis, Mo., as reported in the October 1952 issue of The Journal is in error.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

ATTENTION DOCTORS: Modern Hospital, built in 1946, centrally located in Miami, Florida. Established, going 41 Bed, completely equipped, Medical, Surgical, Obstetrical, all facilities. Registered and approved by the American Medical and American Hospital Associations. Owner deceased. A wonderful opportunity for a group of Doctors. Write 69-74, P. O. Box 1018, Jacksonville, Fla.

WANTED: Association with group or Sanatorium. Married, 43 years old. Geriatric experience. Florida license. Write 69-75, P. O. Box 1018, Jacksonville, Fla.

DOCTOR WANTED: Wonderful opportunity for general practitioner to locate in center of phosphate mining district. Uranium plants are being built on all sides. Steady payrolls, good schools and churches, and friendly people. Offices will be furnished rent free. Contact Mulberry Pharmacy, P. O. Box 455, Mulberry, Fla.

LOCATION DESIRED: Internist, Board diplomate, F.A.P.C., age 49, desires association with physician. Especially qualified in cardiology and metabolic diseases. Prefers West Coast location. Florida license. Write 69-76, P. O. Box 1018, Jacksonville, Florida.

LOCATION DESIRED: Internist, experienced director of clinical laboratory desires position in small hospital. EKG interpretation and consultation. Florida license. Write 69-77, P. O. Box 1018, Jacksonville, Fla.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Balthrop, John E., Jr., Pensacola
Benton, Charles R., Pensacola
Brumback, Clarence L., W. Palm Beach
Collins, Cecil C., Sr., Jacksonville
Fifer, John S., Fort Lauderdale
Grisinger, George F., Jr., Clearwater
Irwin, Richard M., W. Palm Beach
Johnson, L. Wayne, St. Petersburg
Martin, Wayne B., Miami
Monroe, William D., Pensacola
Patterson, Charles A., Pensacola
Pauley, Harvey C., Jr., Bradenton
Robinson, James E., Jr., W. Palm Beach
Taliaferro, Harry F., (Col.) Clearwater
Voyles, Carl M., Jr., St. Petersburg
Wilhoit, William M. C., Pensacola

Announcing The Sixteenth Annual Meeting of
THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY
Conference Headquarters - Municipal Auditorium - March 2 - 5, 1953

GUEST SPEAKERS

J. Lamar Callaway, M.D., Durham, N. C.
Dermatology
A. H. Aaron, M.D., Buffalo, N. Y.
Gastroenterology
Herbert E. Schmitz, M.D., Chicago, Ill.
Gynecology
Carl V. Moore, M.D., St. Louis, Mo.
Hematology
Rudolph H. Kampmeier, M.D., Nashville, Tenn.
Internal Medicine
Henry A. Schroeder, M.D., St. Louis, Mo.
Internal Medicine
Guy L. Odom, M.D., Durham, N. C.
Neurosurgery
Andrew A. Marchetti, M.D., Washington, D. C.
Obstetrics
Harold F. Falls, M.D., Ann Arbor, Mich.
Ophthalmology
J. Vernon Luck, M.D., Los Angeles, Calif.
Orthopedic Surgery
G. Edward Tremble, M.D., Montreal, Can.
Otolaryngology
Arthur P. Stout, M.D., New York, N. Y.
Pathology
Waldo E. Nelson, M.D., Philadelphia, Pa.
Pediatrics
Edward B. D. Neuhauser, M.D., Boston, Mass.
Radiology
George Crile, Jr., M.D., Cleveland, Ohio
Surgery
Robert E. Gross, M.D., Boston, Mass.
Surgery
Charles W. Mayo, M.D., Rochester, Minn.
Surgery
Wyland F. Leadbetter, M.D., Boston, Mass.
Urology

LECTURES, SYMPOSIA, CLINICOPATHOLOGIC CONFERENCES, ROUND-TABLE LUNCHEONS, SURGICAL AND MEDICAL PROCEDURES IN COLOR TELEVISION, MEDICAL MOTION PICTURES AND TECHNICAL EXHIBITS.
(All-inclusive registration fee — $20.00)

THE POSTCLINICAL TOUR TO EUROPE BY SHIP AND PLANE — ENGLAND, FRANCE, SWITZERLAND AND ITALY — MARCH 7-31

For information concerning the Assembly meeting and the tour write Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

COMPONENT SOCIETY NOTES

Broward

In conjunction with the observance of Diabetes Week, the Broward County Medical Society listed the symptoms of diabetes in newspapers and urged that all citizens be tested for diabetes during the week.

Dade

The Dade County Medical Association continues to keep the public informed through two radio programs and one television program. "Tell Me, Doctor" is broadcast Monday through Friday over radio station WQAM; a recorded series including A. M. A. transcriptions is broadcast four times a week over WVCG; and "Modern Living" is presented weekly over WTVJ.

A cocktail-dinner party for press, radio and television representatives was sponsored by the Dade County Medical Association December 4 in the Biscayne Terrace Hotel. This is the fourth year the Association has sponsored the event.

Duval

The December issue of the Bulletin of the Duval County Medical Society contains a complete roster of the members of the Society.

Franklin-Gulf

Guest speaker at the October meeting of the Franklin-Gulf County Medical Society was Dr. DeWitt C. Daughtry of Miami.

Hillsborough

The Hillsborough County Medical Association met with the Pinellas County Medical Society on December 4 to hear Dr. J. Hillis Miller, President of the University of Florida, speak on "The University: Its Proposed Medical Department and Its Public Relations."

Lake

Newly elected officers of the Lake County Medical Society include Drs. John D. Bloom, Groveland, president, and Raymond A. Debo, Eustis, vice president. Re-elected secretary-treasurer was Dr. J. Basil Hall of Mount Dora.

Dr. Leroy H. Oetjen of Leesburg, chairman of the Lake County Public Relations Committee, invited the school principals of the county to a meeting and personally briefed them on the 1953 essay contest for school children on "Why the Private Practice of Medicine Furnishes this Country with the Best Medical Care."

Marion

The annual seafood supper of the Marion County Medical Society was held in place of the November meeting. The supper was held on November 19 at Magnolia Lodge, Ocala.

Monroe

A joint meeting of the Monroe County Medical Society and the Naval Medical Officers, Key West Area, was held on November 20. Speaking at this meeting were Dr. Claire Straith of Detroit, a pioneer in the field of plastic surgery, who spoke on "The Treatment of Facial Injuries and Deformities," and Dr. Robert Kennedy, Assistant Professor of Obstetrics at Wayne University, Detroit, who spoke on "Recent Advances in Obstetrical Practices."

Pasco-Hernando-Citrus

The regular monthly meeting of the Pasco-Hernando-Citrus County Medical Society was held at the Cypress Room at Weeki Wachee in November. The guest speaker was Dr. Thomas E. McKell of Tampa. Other guests included Drs. H. Phillip Hampton of Tampa and William J. Clough and James E. Thompson of Tarpon Springs.

Pinellas

A joint meeting of the Pinellas County Medical Society and the Hillsborough County Medical Association was held on December 4. Guest speaker was Dr. J. Hillis Miller, President of the University of Florida, Gainesville, who spoke on "The University; Its Proposed Medical Department and Its Public Relations."

In connection with National Diabetes Detection Week, the Pinellas County Medical Society worked with the American Diabetes Association in a drive to determine the number of unknown diabetes cases in the county.

Polk

The regular November meeting of the Polk County Medical Society was held in Winter Haven at the Florida Room of the Florida Citrus Building. The meeting was highlighted by a series of technical talks by the Society's own members.

Putnam

Dr. Lawrence G. Hebel, president of the Putnam County Medical Society, made arrangements for two medical exhibits to be displayed at the Putnam County Fair in Palatka, December 11-13. The two exhibits on loan from the American Medical Association were sponsored by the local society. They are listed as "How Disease Bacteria are Spread" and "Diseases Transmitted from Animals to Man."

OBITUARIES

Francis Samuel Skiff

Dr. Francis Samuel Skiff, pioneer physician and surgeon, died July 12, 1952, at the age of nearly 86 years, at his home in Fort Lauderdale. Funeral services were held on July 15, and his remains were taken to Falls Village, Conn., for interment in Grassy Hill Cemetery.

Born on Oct. 5, 1866 in Sharon, Conn., Dr. Skiff belonged to a pioneer New England family and could trace his ancestry back to the Pilgrims who landed at Plymouth Rock. He was a descendant of Edward Fuller and by reason thereof was a member of the General Society of Mayflower Descendants. He was also a member of the Society of Colonial Wars by right of his descent from James Skiff, a member of General Court of Plymouth Colony, who died in 1688.

Dr. Skiff was graduated from the New York University College of Medicine in 1887. After taking postgraduate work at the Johns Hopkins University School of Medicine in Baltimore, he began the practice of medicine in 1887 in Litchfield County, Connecticut. He was engaged in the general practice of medicine and surgery in Connecticut until 1922, with interruptions for specialized work and study in the hospitals of London, Dublin and Edinburgh. For 35 years he ministered to his fellow men in Connecticut, as physician, philosopher, friend and guide. He served their needs during the "horse and buggy" days both in winter and in summer. He also served in the legislature of Connecticut. There he established an enviable reputation for his skill, integrity and humanity.

In December 1922 Dr. Skiff moved to Broward County, Florida, where he continued in the general practice of medicine and surgery until his retirement in April of 1942, at which time he was elected to an honorary membership for life in the Florida Medical Association and the Broward County Medical Society. He was one of the last surviving members of the original Broward County Medical Society, of which he was at one time president. On March 8, 1937, numerous friends joined in celebrating his fifty years in the practice of medicine. He was a member of several benevolent and fraternal organizations, including the Masons and Odd Fellows.

On Oct. 7, 1922, Dr. Skiff was married to Edith Inman, who survives him. They have one son, Charles Frances Skiff, born Jan. 6, 1925, who is presently concluding his professional studies in optometry.

Amasa Dorman Stollenwerck

Dr. Amasa Dorman Stollenwerck of Jacksonville died in St. Vincent's Hospital on July 29, 1952, after a long illness. He was 67 years of age.

A native of Alabama, Dr. Stollenwerck was born in Greensboro on Aug. 9, 1884. He received his academic education at Spring Hill College in Mobile and his medical training at the Tulane University of Louisiana School of Medicine, where he was awarded the degree of Doctor of Medicine in 1908.

Dr. Stollenwerck entered the practice of medicine in Jacksonville in 1909 and became a leading obstetrician in that area. For more than a quarter of a century he was Chief of the Department of Obstetrics at St. Vincent's Hospital. A former Chief of the Department of Gynecology and Obstetrics at the Duval County Hospital, now the Duval Medical Center, he served as President of the Staff of that institution in 1932 and 1933.

A member of the Duval County Medical Society since 1909, Dr. Stollenwerck was for 43 years a member of the Florida Medical Associa-

tion, holding life membership for the last seven years. He was a member of the American Medical Association and of the American College of Surgeons, and was a fellow of the Academy-International of Medicine.

Survivors include the widow, Mrs. Ina B. Stollenwerck, and a stepdaughter, Mrs. Frederick A. Rankin, both of Jacksonville; one sister, Mrs. Carol A. Smith of Decatur, Ala.; and an uncle, C. Y. Stollenwerck, and a cousin, Mrs. O. A. Coleman, both of Greensboro, Ala.

Herbert Edgar Sperry

Dr. Herbert Edgar Sperry of Coral Gables died on July 6, 1952 in Jackson Memorial Hospital, Miami. He was 69 years of age.

Born on Aug. 8, 1882 at Pennfield, N. Y., Dr. Sperry was educated in his native state. He received the degree of Doctor of Medicine from Albany Medical College in Albany in 1908 and then engaged in the general practice of medicine at Rochester, N. Y.

During World War I he entered the service with the rank of captain in the Medical Corps. From 1923 to 1943, Dr. Sperry engaged in the general practice of medicine and surgery in Williamson, N. Y., where he also served as school physician and health officer for the two decades.

In 1944, he came to Florida and opened an office in Coral Gables, devoting his practice to internal medicine and cardiovascular diseases. Locally, he was a Shriner, a member of the Coral Gables Masonic Lodge, the Scottish Rite and York Rite bodies, the American Legion and the First Methodist Church.

A member of the Dade County Medical Association, Dr. Sperry was also a member of the Florida Medical Association and the American Medical Association.

Surviving are the widow, Mrs. Gladys Sperry, and one stepson, Robert.

Clifford LeRoy Adams, Jr.

Dr. Clifford LeRoy Adams, Jr., of Live Oak met sudden death in his office on Aug. 3, 1952. He was 43 years of age.

A member of a prominent North Florida family, Dr. Adams was born in Jasper on Dec. 11, 1908. He was the son of C. LeRoy Adams, Sr., and Marie Thaggard Adams. After first studying pharmacy, he entered the University of Arkansas School of Medicine in 1941. He was awarded the degree of Doctor of Medicine by that institution in 1944 and completed an internship in Little Rock before returning to his native state. Since 1945 he had engaged in the practice of medicine in Live Oak. In addition, he operated one of the largest livestock farms in the state near Lake City.

In his first active political venture, Dr. Adams won the Democratic nomination for state senator last May and was unopposed for the general election. But for his untimely death, he would have followed in the footsteps of his grandfather, the late Frank Adams, who served two terms as president of the Florida Senate, and of his uncle, the late R. Stanley Adams, who was a senator from the Seventeenth District.

A member of the Suwannee County Medical Society, Dr. Adams also held membership in the Florida Medical Association and the American Medical Association.

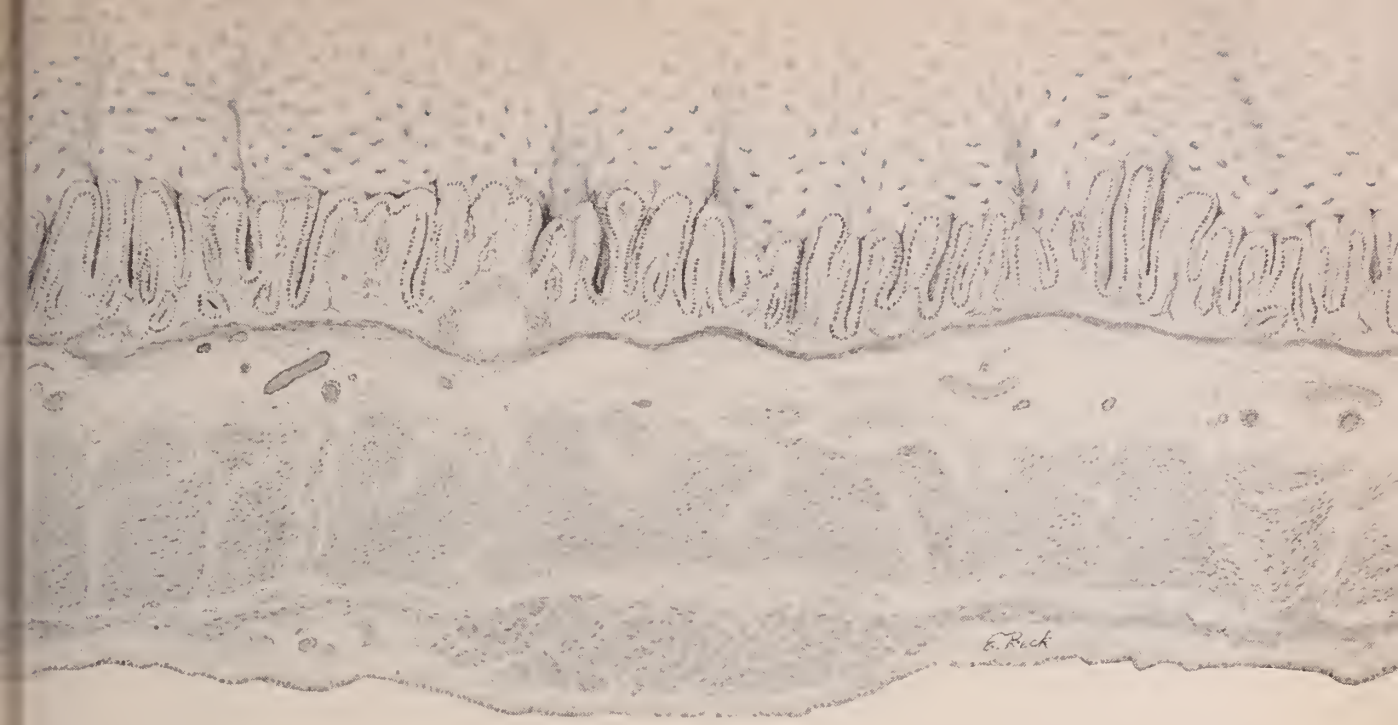
Surviving are the widow, the former Florrie Lee Edwards, and one daughter, Mrs. W. W. Jernigan, both of Live Oak; his mother, Mrs. C. LeRoy Adams, Sr., of Jasper; two sisters, Mrs. Nolan Wilkes of Jasper and Mrs. Maurice Villeneuve of Tallahassee; and two grandchildren.

William Hawley Weems

Dr. William Hawley Weems of West Palm Beach died on Aug. 30, 1952, on the north side of Lake Okeechobee, where he was accidently killed in an automobile accident while riding as a passenger.

Dr. Weems was born in Clopton, Ala., on Nov. 9, 1909. His family had lived there for many years, and his father was a physician in that community. Dr. Weems was graduated from the High School at Ozark, Ala., and entered the University of Alabama in 1927. He received the Bachelor of Science degree and the Master of Science degree in Medicine in 1933. He then matriculated at the Rush Medical College, University of Chicago, where he was awarded the degree of Doctor of Medicine in 1935. There followed one year's internship at Michael Reese Hospital, one year's residency in Surgery at Los Angeles County General Hospital and a six months' residency at the Good Samaritan Hospital in West Palm Beach.

Dr. Weems became full time County Physician for Palm Beach County in 1937, after resigning from Good Samaritan Hospital. He served in this



Normal peristaltic action results from activity of the muscle layers as they are gently distended by bulk within the intestine; mucosal irritants cause overactivity of the muscle layers resulting in hyperperistalsis or spasm.

Corrective Action of Metamucil® in Abnormal Physiology of Constipation

Abnormally prolonged colonic retention, whether in a spastic or an atonic colon, demands the greatest care to assure correction.

The mucosa does not require stimulating; hence, stimulating cathartics, "roughage" and other physical and chemical irritating measures, are today often considered irrational.

On the other hand, the muscularis does require a stimulus to initiate peristalsis. This physiologic stimulus is the mechanism by which bland distention of the colon establishes a reflex, with the muscularis at the terminus of the reflex arc.

Metamucil literally reeducates the sluggish and also the spastic colon. Taken with adequate amounts of water, Metamucil forms a smooth, hydrophilic colloid. As this colloidal mass passes through the large intestine, it exerts a gentle, distending pressure within the lumen, thus initiating the peristaltic reflex necessary for evacuation.

A program of Metamucil therapy helps to restore proper tone to the intestinal musculature, thereby establishing proper bowel habits.

Metamucil® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

G. D. Searle & Co.

Research in the Service of Medicine

Cook County Graduate School of Medicine

POSTGRADUATE COURSES — WINTER 1952-53

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting January 19, February 2, February 16. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 2. Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 16. Basic Principles in General Surgery, Two Weeks, starting March 30. Gallbladder Surgery, Ten Hours, starting April 20. Surgery of Colon & Rectum, One Week, starting March 2. General Surgery, One Week, starting February 9. General Surgery, Two Weeks, starting April 20. Fractures & Traumatic Surgery, Two Weeks, starting March 2.

GYNECOLOGY—Intensive Course, Two Weeks, starting February 16. Vaginal Approach to Pelvic Surgery, One Week, starting March 2.

OBSTETRICS—Intensive Course, Two Weeks, starting March 2.

PEDIATRICS—Intensive Course, Two Weeks, starting April 6.

MEDICINE—Intensive General Course, Two Weeks, starting May 4. Electrocardiography & Heart Disease, Two Weeks, starting March 16. Allergy, One Month and Six Months, by appointment.

UROLOGY—Intensive Course, Two Weeks, starting April 13. Ten-Day Practical Course in Cystoscopy starting every two weeks.

DERMATOLOGY—Intensive Course, Two Weeks, starting May 11.

Teaching Faculty:
Attending Staff of Cook County Hospital
Address:
Registrar, 707 South Wood Street
Chicago 12, Illinois

capacity from November 1937 to 1940, resigning to enter private practice. While serving as County Physician, Dr. Weems established numerous venereal and health clinics throughout the entire county, where hundreds of indigent patients were treated, and did much to promote better medicine and health care in the county. He was greatly interested in mental hygiene clinics to serve the people and spread information on mental diseases.

Dr. Weems held a pilot's license under the CAA and was Flight Surgeon for the CAP before entering World War II to become a flight surgeon. He entered military service on July 1, 1942. After spending some time at MacDill Field in Tampa and attending the Flight School for Doctors at Randolph Field, Texas, he was transferred to South Carolina, where he was Flight Surgeon at Myrtle Beach Bombing Range. From that station he was transferred overseas, serving in the Southwest Pacific Theater. He was honorably discharged in November 1945 with the rank of major. He held a reserve commission in the Air Force.

Dr. Weems was a member of the Phi Chi Medical Fraternity, Kiwanis Club, West Palm Beach Elks Club, Q. V. Flying Club and Chamber of Commerce. He was also a member of the Baptist church. He held membership in the Palm Beach County Medical Society, serving as secretary in 1947, the Florida Medical Association and the American Medical Association. He was an active member of the Academy of General Practice.

Dr. Weems was a member of the staffs of the Good Samaritan, St. Mary's and Pine Ridge hospitals in West Palm Beach.

Dr. Weems is survived by his widow, Nell Gunter Weems; two daughters, Margaret and Catherine; two brothers, Dr. Nathaniel M. Weems of Boynton Beach and Mr. Max Gerome Weems of Clopton, Ala.; and one sister, Mrs. Louise Weems Reynolds of Clopton, Ala.

Charles Hubert Petteway

Dr. Charles H. Petteway of Lakeland died on Sept. 27, 1952, of myelogenous leukemia at the age of 33. He was in practice there in otorhinolaryngology.

Dr. Petteway was born on Nov. 30, 1919, in Lakeland. He was graduated from the Lakeland High School in 1936, attended Tulane University

from 1936 to 1942, and in the latter year was graduated in medicine. He interned at the Charity Hospital in New Orleans during the year 1943 and had a residency in orthopedics at Jackson Memorial Hospital in Miami in 1944.

After serving in the Army in 1945 and 1946, he was in general practice for seven months in Bogalusa, La., before taking his ear, nose and throat training at Tulane and at the Eye, Ear, Nose & Throat Hospital in New Orleans from 1947 to 1949. He began practice in ear, nose and throat in Lakeland in May 1949 and passed his American Board examinations in Otorhinolaryngology in 1951. He was a member of the Polk County Medical Society, the Florida Medical Association and the American Medical Association as well as the American Boards. He held membership in the First Methodist Church and was a member of the Board of the Children's Home Society and of Pi Kappa Alpha and Phi Chi fraternities.

Surviving are the widow, Meredith; one son, Robert Charles, aged 7; and one daughter, Susan, aged 7 months.

Dr. Petteway's life exemplified all that was fine and honorable in his profession, and his death at an early age from a condition of which he had been fully aware for three years was keenly felt by his colleagues and his patients alike. He had courage and self discipline which are granted to but few men and exhibited such a nobility of spirit in the face of adversity as to inspire a true reverence in all who knew him well. Under the greatest handicaps and physical discomfort, he proceeded to practice his profession until just a day or two before his death. His life showed an equinimity which few possess and exemplified the true faith and dignity of man. His quiet fortitude and assurance continue to be an unending inspiration to his medical colleagues in these troubled times.

HIGHLAND HOSPITAL, INC.

FOUNDED IN 1904

Asheville, North Carolina

AFFILIATED WITH DUKE UNIVERSITY

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a sixty-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D.,
Diplomate in Psychiatry
Medical Director

ROBT. L. CRAIG, M.D.,
Diplomate in Neurology and Psychiatry
Associate Director

BRAWNER'S SANITARIUM

Established 1910

SMYRNA, GEORGIA
(Suburb of Atlanta)

For Nervous and Mental Disorders
Drug and Alcohol Addiction
Electro-Shock in selected cases

JAMES N. BRAWNER, M.D., Medical Director
ALBERT F. BRAWNER, M.D., Department for Men
JAMES N. BRAWNER, JR., M.D., Department for Women

CONVENTION PRESS

218 WEST CHURCH STREET
JACKSONVILLE
FLORIDA

Commercial and
Publication
Printing

WOMAN'S AUXILIARY
TO THE
FLORIDA MEDICAL ASSOCIATION
OFFICERS

Mrs. Herschel G. Cole, President.....*Tampa*
Mrs. Thomas C. Kenaston, President-elect.....*Cocoa*
Mrs. Richard F. Stover, 1st Vice Pres.....*Miami*
Mrs. Nelson A. Murray, 2nd Vice Pres.....*Jacksonville*
Mrs. Reaves A. Wilson, 3rd Vice Pres.....*Sarasota*
Mrs. Taylor W. Griffin, 4th Vice Pres.....*Quincy*
Mrs. Albert G. Love, IV, Recording Sec'y.....*Gainesville*
Mrs. Herbert B. Lott, Corresp'd. Sec'y.....*Tampa*
Mrs. Samuel S. Lombardo, Treasurer.....*Jacksonville*

COMMITTEE CHAIRMEN

Mrs. Charles F. Henley, Finance.....*Jacksonville*
Mrs. Edward F. Shaver, Today's Health.....*Tampa*
Mrs. Alvin L. Mills, Legislation.....*St. Petersburg*
Mrs. C. Russell Morgan, Jr., Public Relations....*Miami*
Mrs. William G. Meriwether, Reference.....*Plant City*
Mrs. Sherrel D. Patton, Civil Defense.....*Sarasota*
Mrs. Carroll V. Herron, Projects.....*Daytona Beach*
Mrs. Julius Alexander, Program.....*Miami*
Mrs. James T. Cook, Jr., Bulletin.....*Marianna*
Mrs. George H. Putnam, Historian.....*Gainesville*
Mrs. Angus D. Grace, Parliamentarian.....*Fort Myers*
Mrs. Alfonso F. Massaro, Revisions.....*Tampa*
Mrs. John E. Maines, Jr., Stu. Loan Fund....*Gainesville*
Mrs. Arthur R. Knauf, Medaux.....*Tampa*
Mrs. Charles McD. Harris, Jr., Study Group.....*W. P. Beach*
Mrs. C. Robert DeArmas, Auxiliary Writer for State Medical Journal.....*Daytona Beach*
Mrs. Edward W. Cullipher, Stu. Nurse Recruit. *Miami*
Mrs. Leffie M. Carlton, Jr., Hospitality.....*Tampa*

The Time to Give

When a farmer has reaped his crop he knows from his harvest whether his work has been well done. We all reap the harvest which results from our sowing. As this is written, November is behind us, and we have the joyous period of giving and good will ahead, followed by the dawn of a new year.

Because it is as important to the doctor and his wife as it is to the farmer and his wife to study the field before seeding of a new crop, we pause for reflection. While the ground lies fallow, it is good to give thought to the nourishment needed if the soil is to yield bountifully. For, what we put into anything determines what we get out of it.

An essential ingredient to ground work in any field is an awareness that what we do not matters as much as what we do. This ingredient is labeled Attitude. Attitude is a potent factor in any endeavor. The right attitude, one of belief and loyalty to one's commitment, stimulates and nourishes a group.

Now, as never before, we must give of ourselves in attention to even the smallest detail in the organization. We must guard against the eroding effects of back-wash which follows sustained effort so as not to wash away the enthusiasm of those who feel inconsequential, or who feel the Auxiliary to be inconsequential unless there is a threat — a challenge.

This attitude can be accomplished. We become as we think. Floridians are always surprised when the Christmas lights go on and signs go up heralding the Yuletide. The trimmings belie the languor summery weather encourages, but time marches on and it is always later than we think. So, in spite of inclination we are caught up in the contagion of spirit, and, thereby, we create the season to give. Thinking makes it so — so be thinking and making plans for a constructive and Happy New Year!

Mrs. C. Robert DeArmas

BOOKS RECEIVED

Handbook on V.D. By Carroll T. Bowen, M.D. Pp. 66. Price, $1.25. Coral Gables, Fla., University of Miami Press, 1952.

This new and authoritative work, with foreword by Philip Wylie, presents highly organized information on venereal disease. It is especially prepared for college and high school students, nurses, military personnel, adult education groups, and patients who have not understood the import of their diseases.

The book was written for the sole purpose of educating people all over the world on this still important subject. It meets the need for and makes available to the layman a comprehensive small volume containing up-to-date accurate information on all of the venereal diseases.

The author, Dr. Carroll T. Bowen, Director, Venereal Disease Control, Miami, has had a brilliant career with the United States Public Health Service and for the past 18 years has been engaged in venereal disease control work in various parts of the United States. Since coming to Florida, he has served as Director of Venereal Disease Control for Duval County, and Health Officer for Broward and Levy counties. In 1943, he built and became superintendent of Florida's first rapid treatment center at Ocala. He produced the clinical photography for the nation's first full length technical color film on syphilis.

Helping Parents Understand the Exceptional Child. Pp. 42. Child Research Clinic, The Woods Schools, Langhorne, Pa., 1952.

"The Cornerstone of Understanding" was the theme selected this year for the annual spring conference on education and the exceptional child held under the auspices of the Child Research Clinic of The Woods Schools at Langhorne, Pa. Published in booklet form, the proceedings of this conference contain five addresses: "The Emotional Quandaries of Exceptional Children," by Dr. Leo Kanner, Children's Psychiatric Service, Harriet Lane Home for Children, Johns Hopkins Hospital, Baltimore; "The Psychology of the Exceptional Child," by Dr. Seymour B. Sarason, Associate Professor of Psychology, Yale University, New Haven, Conn.; "How the Schools Can Help Them," by Arthur S. Hill, chief of the section on Exceptional Children and Youth, Office of Education, Federal Security Agency, Washington, D. C.; "Growth of Social Responsibility for the Exceptional Child," by Katherine G. Ecob, Consultant for Veterans Administration Mental Clinics, New York; and "The Parents of the Exceptional Child," by Clara Savage Littledale, Editor, Parents' Magazine, New York.

Copies of this booklet dealing with the problems of the retarded child may be obtained free from the Child Research Clinic, The Woods Schools, Longhorne, Pa.

Advertisement

From where I sit
by Joe Marsh

They'll Do It Every Time

You know where Hammy Jackson lives—on that small dead-end street off Maple Avenue near the municipal library? Well, about a month ago, the town finally put up a traffic sign on the corner there saying: "*No thoroughfare . . . Dead End.*"

Yesterday Hammy dropped by to see us. "*Can't understand it,*" he says. "*Hardly anybody ever drove down our street before—but, now, since they went and put that sign up, there's been more cars than ever turning around in my driveway.*"

From where I sit, these people who bother Hammy on his one-way street are the same as those who automatically ignore a Wet Paint sign and touch their finger on a freshly painted surface. But you can't change human nature. People like to think for themselves and to choose for themselves. Whether it be following a chosen profession or a little thing like a choice of a beverage at mealtime, let's not feel we're obliged to "point the way" for the other fellow.

Joe Marsh

Copyright, 1952, United States Brewers Foundation

The Story of the Adaptation Syndrome (Told in the Form of Informal, Illustrated Lectures). By Hans Selye, M.D., Ph.D. (Prague), D.Sc. (McGill), F.R.S. (Canada). Pp. 225. Montreal, Canada, Acta, Inc., Medical Publishers, 1952.

This book is a brief summary of the author's work on the adaptation syndrome, "intentionally quite subjective and personal." In seven informal lectures Dr. Selye unfolds the "Story of the Adaptation Syndrome," making no attempt to cover the entire pertinent literature systematically. He outlines the warmly personal style an eyewitness account of the most striking events in the history of the investigation of the stress problem — the concept of the adaptation syndrome, its history, its mechanism, its clinical implications and the light it begins to shed upon the understanding of disease in general.

To a bird's eye view of the picture as a whole at the present time, he adds his view of the most important outcome and probable future of research on stress and the adaptive hormones. "What do the hormones do?" is supplanted now by "What adaptive reactions do they influence?" "Which diseases are caused by the excessive function or destruction of an endocrine gland?" becomes today "In which diseases has the endocrine status a decisive influence?" There emerges a new and somewhat more complex pathology in which the main objects of study are no longer individual "pathogens," but rather "pathogenic situations."

In summary, Dr. Selye states: "Thus, to my mind, the most important contribution of research on stress is that it has furnished an objective, scientific basis for the development of a new approach to the treatment of disease.

"This is neither specific causal nor specific symptomatic therapy, but a treatment based upon the imitation and perfection of Nature's own auto-pharmacologic responses. These defensive reactions have become exquisitely adapted to our needs, through countless centuries of evolution so that we may meet all the usual assaults against health and life to which man is commonly exposed. A therapy which thus attempts to co-operate intelligently with the natural healing powers of the body could not fail to inspire confidence."

The Low Fat Diet Cookbook. By Dorothy Myers Hildreth and Eugene A. Hildreth, M.D. Pp. 148. Price, $2.95. New York, Medical Research Press, 1952.

Extensive research has indicated that a high level of cholesterol in the blood is responsible for atherosclerosis, the most painful and dangerous form of the circulatory diseases of advancing age. It has shown that by cutting down animal and vegetable fats in the diet the cholesterol content of the blood may be reduced and controlled. The low fat diet thus makes possible the prevention and treatment of atherosclerosis and has become accepted medical practice by an increasing number of physicians.

The Low Fat Diet Cookbook presents all of the basic facts of the low fat diet: how to plan and follow a low fat diet; how to prepare over 200 medically tested and appetite-tempting dishes, including low fat roasts, fish, poultry, gravies, dressings, desserts, salads, sandwiches, sauces and many more; how to adjust the low fat diet to lose or gain weight; how to calculate the fat content of basic foods in preparing favorite dishes; and how to plan menus for an entire week of delicious low fat meals.

Dorothy Myers Hildreth, experienced dietitian, has collaborated with her husband, Dr. Hildreth, in research on the low fat diet, and both are thoroughly versed in the subject.

Dr. Francis C. Wood, Professor of Medicine at the University of Pennsylvania School of Medicine and Chief of the Medical Clinic of the Hospital of the University of Pennsylvania, states in the introduction that the evidence of years of research indicates that "atherosclerosis is not necessarily an inevitable concomitant of aging" when the low fat diet is prescribed.

TUCKER HOSPITAL, INC.

212 West Franklin Street

RICHMOND, VIRGINIA

A private hospital accepting for diagnosis and treatment organic neurological conditions, selected psychiatric and alcoholic cases, metabolic disturbances of an endocrine nature, individuals who are having difficulty with their personality adjustments, and children with behavior problems. Patients with general medical disorders admitted for treatment under our staff of visiting physicians.

Under the Professional Charge of

DR. HOWARD R. MASTERS,
DR. JAMES ASA SHIELD AND ASSOCIATES

W. Guy Black

HOME FOR FUNERALS
170 EAST CHURCH
TELEPHONE 2-3146

Complete Facilities
Complete Funeral Service
Call Orlando 2-3146
For Oxygen-Equipped
AMBULANCE
SERVICE
W. Guy Black
Licensed Funeral Director

Janet's Nursery for Babies

P. O. Box 191
OSPREY, FLORIDA
Phone RIngling 4-1647

A Nursery for Handicapped Babies

For Information write
H. KEITH JACOBUS
P. O. Box 191
Osprey, Florida

#8. Spacious Grounds of Miami Medical Center
Chatery in Background.

MIAMI MEDICAL CENTER

P. L. DODGE, M.D.
Medical Director and President

1861 N. W. South River Drive
Phones 2-0243 — 9-1448

A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures — Psychotherapy, Insulin, Electroshock, Hydrotherapy, Diathermy and Physiotherapy when indicated. Adequate facilities for recreation and out-door activities. Cruising and fishing trips on hospital yacht.

Information on request
Member American Hospital Association

HILL CREST SANITARIUM

FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

Thoroughly modern in architecture and construction. Eight departments — affording proper classification of patients. All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

James A. Becton, M.D., Physician-in-charge — James Keene Ward, M.D., Associate Physician

P. O. Box 2896, Woodlawn Station, Birmingham, Alabama — Phones 9-1151 and 9-1152

THE EARLE JOHNSON SANATORIUM

For the care of nervous, mental, senile, alcoholic, and addicted cases. **Moderate rates.**

Operated by C. Earle Johnson, Jr., M.D., Psychiatrist-in-Chief, F.A.P.A., F.A.C.P. Diplomate of the American Board of Psychiatry and Neurology.

The most modern and effective psychiatric methods are employed. Gradual reduction in the addictions; Antabuse treatment for alcoholism.

Telephone: 3-3369 or 3-3360
Write: Drawer 106
Meridian, Mississippi

Allen's Invalid Home

MILLEDGEVILLE, GA.
Established 1890
For the treatment of
NERVOUS AND MENTAL DISEASES

Grounds 600 Acres
Buildings Brick Fireproof
Comfortable Convenient
Site High and Healthful

E. W. ALLEN, M.D., *Department for Men*
H. D. ALLEN, M.D., *Department for Women*
Terms Reasonable

BISCAYNE HOSPITAL

6339 Biscayne Blvd.
MIAMI 38, FLORIDA

Members of the Dade County Medical Association are acquainted with the high type of service rendered.

David Collins, Superintendent

Registered, American Medical Association
Phone 7-4544

S. A. Kyle — *Funeral Director*

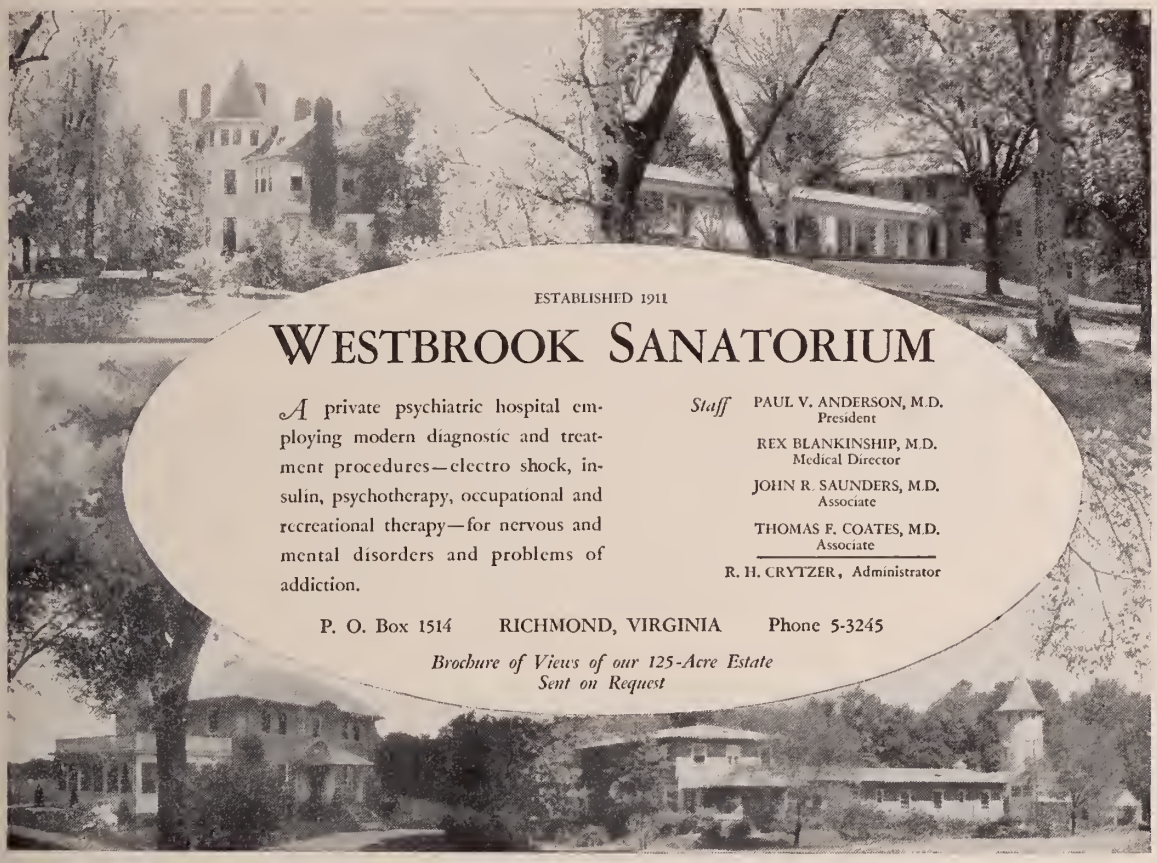
MEMBER National Selected Morticians BY INVITATION

17 WEST UNION STREET
JACKSONVILLE 2, FLORIDA
Phones 5-3766 5-3767

one drop tells the story

by simply adding ONE drop of urine to ONE drop of reagent, Ru Drop Test offers a clinically accurate method . . . Unconditionally Guaranteed . . . for the complete chemical screening of all urines by One Uniform Procedure in ONE MINUTE. A comprehensive brochure on One Minute Ru Test is available at your request

ORGO PRODUCTS COMPANY
WALTERIA, CALIFORNIA



ESTABLISHED 1911

WESTBROOK SANATORIUM

A private psychiatric hospital employing modern diagnostic and treatment procedures—electro shock, insulin, psychotherapy, occupational and recreational therapy—for nervous and mental disorders and problems of addiction.

Staff
PAUL V. ANDERSON, M.D.
President
REX BLANKINSHIP, M.D.
Medical Director
JOHN R. SAUNDERS, M.D.
Associate
THOMAS F. COATES, M.D.
Associate
R. H. CRYTZER, Administrator

P. O. Box 1514 RICHMOND, VIRGINIA Phone 5-3245

Brochure of Views of our 125-Acre Estate Sent on Request

ONE OF AMERICA'S FINEST INSTITUTIONS . . .

BROOK HAVEN MANOR...

with a well trained staff of nurses and attendants, fills the need for a high class, ethical nursing home.

Convalescents and elderly patients receive individual attention in these lovely surroundings.

Alcoholics, drug addicts and mental patients are not accepted.

Physicians are invited to continue supervision of their patients.

Rates moderate, based on individual needs.

Dedicated to the Welfare of the Convalescent and Elderly

BROOK HAVEN MANOR SANITARIUM

STONE MOUNTAIN, GA.

ATTENDING PHYSICIANS:
Dr. J. Rufus Evans
Dr. Willis McCurdy

NURSES:
Miss Elizabeth C. Hancock
Mrs. Carro Henderson
Mrs. Cumei Andrei, *Chief Dietician*

Dilaudid hydrochloride

(dihydromorphinone hydrochloride)

COUNCIL ACCEPTED

Powerful opiate analgesic - dose, 1/32 grain to 1/20 grain.

Potent cough sedative - dose, 1/128 grain to 1/64 grain.

Readily soluble, quick acting.

Side effects, such as nausea and constipation, seem less likely to occur.

An opiate, has addictive properties.

Dependable for relief of pain and cough, not administered for hypnosis.

● Dilaudid is subject to Federal narcotic regulations. Dilaudid, Trade Mark Bilhuber.

Bilhuber-Knoll Corp. Orange, N. J.

BALLAST POINT MANOR

Care of Mild Mental Cases, Senile Disorders
and Invalids
Alcoholics Treated

Aged adjudged cases will be accepted on either permanent or temporary basis.

ACCREDITED HOSPITAL FOR NEUROLOGICAL PATIENTS by
American Medical Assn.
American Hospital Assn.
Florida Hospital Assn.

5226 Nichol St.
Telephone 62-2332

DON SAVAGE
Owner and Manager

P. O. Box 10368
Tampa 9, Florida

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
ledical Association	Robert B. McIver, Jacksonville	Samuel M. Day, Jacksonville	Hollywood, Apr. 26-29, '53
ledical Districts	Eugene G. Peek, Jr., Ocala	Council Chairman	
hwest	Francis M. Watson, Marianna	Benjamin A. Wilkinson, Tallahassee	Tallahassee, 1953
heast	William C. Thomas, Jr., Gainesville	Eugene L. Jewett, Orlando	St. Augustine, 1953
hwest	Emmett E. Martin, Haines City	Hugh G. Reaves, Sarasota	Tampa, 1953
heast	Erasmus B. Hardee, Vero Beach	Donald W. Smith, Miami	West Palm Beach, 1953
pecialty Societies			
of General Practice	Edward F. Shaver, Tampa	Frank T. Linz, Tampa	Hollywood, Apr. 26, '53
ociety	Nelson Zivitz, Miami Beach	Solomon D. Klotz, Orlando	" "
logists, Soc. of	John T. Stage, Jacksonville	Breckenridge W. Wing, Orlando	" "
Am. Coll. Chest Phys	Alexander Libow, Miami Beach	DeWitt C. Daughtry, Miami	" "
l Syph., Soc. of	Lewis Capland, Miami Beach	Morris Waisman, Tampa	" "
fficers' Society	George W. Edwards, II, Orlando	Lorenzo L. Parks, Jacksonville	" "
& Railway Surgeons	John H. Mitchell, Jacksonville	William H. Chapman, Jacksonville	" "
& Psychiatry	W. Tracy Haverfield, Miami	Roger E. Phillips, Orlando	" "
Gynec. Society	Dorothy D. Brame, Orlando	J. Champneys Taylor, Jacksonville	" "
& Otol., Soc. of	Joseph W. Taylor, Sr., Tampa	Carl S. McLemore, Orlando	" "
ic Society	Arthur H. Weiland, Coral Gables	Edward W. Cullipher, Miami	" "
sts, Society of	Robert J. Poppiti, Miami Beach	Alfred E. Cronkite, Fort Lauderdale	" "
Society	Charlotte C. Maguire, Orlando	Wesley S. Nock, Coral Gables	" "
ic Society	Alex. E. Rosenberg, Miami Bch.	George Williams, Jr., Miami	" "
cal Society	Thomas H. Lipscomb, Jacksonville	A. Judson Graves, Jacksonville	" "
l Society	George H. Putnam, Gainesville	David W. Goddard, Daytona Beach	" "
cience Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 6, '53
Banks, Association	Donald W. Smith, Miami	Mr. J. M. Potts, Miami	Miami, May, 1953
ross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
hield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 26, '53
Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	
Society, State	W. G. McLeod, D.D.S., Pensacola	Coleman Brown, D.D.S., Tampa	St. Petersburg, Apr. 20-23, '53
Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
al Association	Mr. T. F. Little, Daytona Beach	Mr. Tracy B. Hare, Miami	Miami, Nov. '53
l Examining Board	Ralph B. Spires, DeFuniak Springs	Homer L. Pearson, Jr., Miami	Jacksonville, June 28-30, '53
l Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Association, State	Mrs. Mary Livingston, W. P. Beach	Mrs. Idalyn Lawthon, Tampa	Tampa, Nov. '53
aceutical Association, State	Mr. Clyde Morris, Daytona Beach	Mr. R. Q. Richards, Ft. Myers	St. Petersburg, May, '53
Health Association	Mr. Angus Laird, Tallahassee	Mr. Fred B. Ragland, Jacksonville	Tampa, 1953
ulosis & Health Assn.	Leffie M. Carlton, Jr., Tampa	Mrs. L. C. Conant, Fort Myers	Jacksonville, May 14-15, '53
n's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	Hollywood, Apr. 26-28, '53
Medical Association	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	New York, June 1-5, '53
. Clinical Session	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	St. Louis, Dec. '53
Medical Association	Walter C. Jones, Miami	Mr. C. P. Loranz, Birmingham	Atlanta, 1953
Medical Association	B. W. McNease, Fayette	Douglas L. Cannon, Montgomery	Birmingham, Apr. 16-18, '53
Medical Assn. of	C. F. Holton, Savannah	Mr. Sid Wrightsman, Atlanta	Savannah, May 10-13, '53
spital Conference	Mr. Norman Losh, Orlando	Mr. D. O. McClusky, Tuscal'sa, Ala.	New Orleans, April 8-10, '53
tern Allergy Assn.	Clarence Thomas, Nashville, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Havana, Cuba, Mar. 26-29, '53
tern, Am. Urological Assn.	William Miner, Covington, Ky.	Sidney Smith, Raleigh, N. C.	Nashville, May, '53
tern Surgical Congress	H. L. Claud, Washington, D. C.	B. T. Beasley, Atlanta	Louisville, Mar. 9-12, '53
ast Clinical Society	Hays Zieman, Mobile, Ala.	William Atkinson, Mobile, Ala.	Mobile, Oct., '53

MIAMI RETREAT SANATORIUM

FOUNDED 1927

For Nervous and Mental Disorders, Alcohol and Drug Addiction

STAFF OF EIGHT NEUROPSYCHIATRISTS
New X-Ray Diagnostic Treatment Facilities
Comfortable AIR-CONDITIONED rooms, suites

79TH STREET AT MIAMI AVENUE
MIAMI 38, FLORIDA

Phone 7-1824

PROOF WITH ONE PUFF?

So distinct is the difference between PHILIP MORRIS and *any* other leading brand, that we believe you will notice it with a single puff. Won't you try this simple test, Doctor, and see?

Take a PHILIP MORRIS and any other cigarette

1. Light up either one first. Take a puff—get a good mouthful of smoke—and s-l-o-w-l-y let the smoke come directly through your nose.
2. Now, do exactly the same thing with the other cigarette.

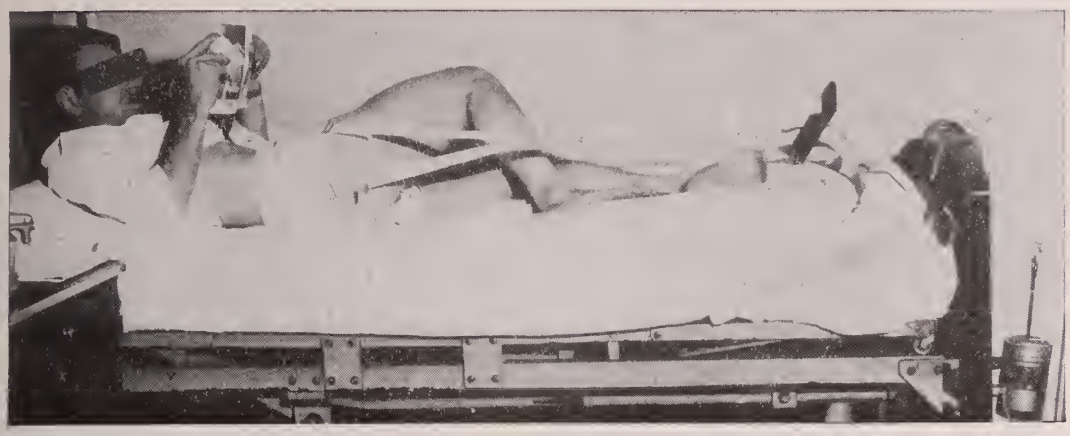
You will notice a distinct difference between PHILIP MORRIS and any other leading brand.

PHILIP MORRIS

Philip Morris & Co., Ltd., Inc., 100 Park Avenue, New York 17, N. Y.

WHAT'S NEW?

CAMP-VARCO PELVIC TRACTION BELT



Model 810

Similar to a sacro-iliac support with strap adjustment in the front. The patented soft hip section guards against pressure on prominent hip crests and helps anchor the support. Equipped with "Y" shaped non-elastic adjustable straps to spreader. Spreader is additional. Sized by actual hip measurement taken 2" below anterior spine. Cream coutil, flannel lined. All sizes 32 to 42.

An effective and practical adjunct in the treatment of low back injuries, following the tested designs of Dr. Samuel Varco. Clinicians regard it as a marked improvement over present traction methods. In no way does it restrict the use of any other modalities which may be desired. Ease of application, cheerful acceptance by the patient, its availability for **men, women and children** at hospital or home and a decrease in the demands on the nursing staff make the Camp-Varco Traction Belt a distinct contribution.

PRICES

No. 810 Belt **$15.00**

Spreader **2.00**

Bucks Extension available

No. 112 complete with Cord and weights **$18.00**

AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A. Quality and Service

Anderson Surgical Supply Co.

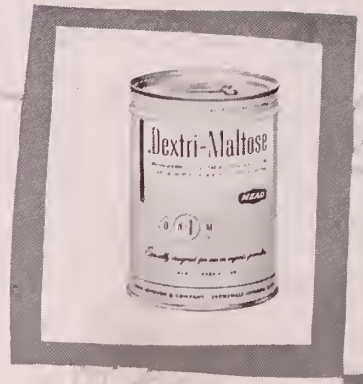
Established 1916

Telephone 5-2560
40-42 W. DUVAL STREET
P. O. Box 1799
JACKSONVILLE, 1, FLORIDA

Telephone M-8504
1101-1105 TAMPA STREET
P. O. Box 1228
TAMPA 1, FLORIDA

Telephone 7-4589
21 3rd STREET N.
ST. PETERSBURG, FLORIDA

NEW YORK ACADEMY OF 2
MEDICINE
2 E 103RD ST
NEW YORK N Y 29 J C-E

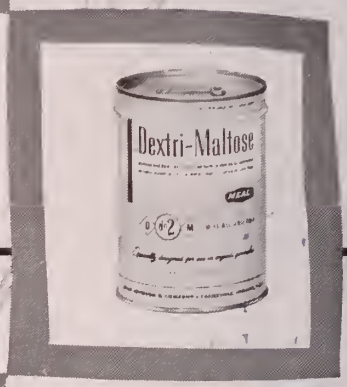


For routine infant feeding. The basic Dextri-Maltose product.

Dextri-Maltose

MEAD

MEAD JOHNSON & COMPANY
Evansville 21, Ind., U.S.A.



Especially indicated for premature infants. Contains 50 mg. ascorbic acid per ounce.

To aid in counteracting constipation. Contains 3% potassium bicarbonate.

designed with singleness of purpose

Designed and manufactured specifically for infant formulas, Dextri-Maltose® has an unequaled background of successful clinical use. Safety for your infant patients is assured by the dry form of this carbohydrate, meticulous laboratory control at all stages in its manufacture, and hermetically sealed, key-opening cans. Dextri-Maltose is palatable but not sweet; does not create a "sweet tooth" in infants. Easily measured without spilling or waste and almost instantly soluble, Dextri-Maltose is convenient for the mother.

Local representative: Roger J. McElroy, 3181 McDonald Street, Coconut Grove 33, Florida, 4-4124.

The Journal OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXIX FEBRUARY, 1953 No. 8

IN THIS ISSUE

Cortisone and ACTH in Eclampsia
William M. Howdon and B. L. Ludwig

Typhoid Carriers
William A. Walter

County Health Unit
Paul W. Hughes

Our Midwife Problem
Clarence L. Brumba

Next Month

Program — 79th Annual Convention
Hollywood, April 26-29, 1953

FEB 10 1953
LIBRARY

OFFICIAL PUBLICATION OF THE
FLORIDA MEDICAL ASSOCIATION

in the hands of the physician

Often the critical evaluation of the drug to be administered is as important to the patient's recovery as is the diagnosis of his condition. In each case correct procedures can be determined only by the physician.

Chloromycetin is eminent among drugs at the disposal of the medical profession. Clinical findings attest that, in the hands of the physician, this widely used, broad spectrum antibiotic has proved invaluable against a great variety of infectious disorders.

The many hundreds of clinical reports on CHLOROMYCETIN emphasize repeatedly its exceptional tolerance as demonstrated by the infrequent occurrence of even mild signs and symptoms of gastrointestinal distress and other side effects in patients receiving the drug.

Similarly, the broad clinical effectiveness of CHLOROMYCETIN has been established, and serious blood disorders following its use are rare. However, it is a potent therapeutic agent, and should not be used indiscriminately or for minor infections—and, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

Chloromycetin®

notably effective

well tolerated

BROAD SPECTRUM ANTIBIOTIC

CHLOROMYCETIN (chloramphenicol, Parke-Davis)
is available in a variety of forms, including:

CHLOROMYCETIN KAPSEALS,® 250 mg., bottles of 16 and 100.
CHLOROMYCETIN CAPSULES, 100 mg., bottles of 25 and 100.
CHLOROMYCETIN CAPSULES, 50 mg., bottles of 25 and 100.
CHLOROMYCETIN OPHTHALMIC OINTMENT, 1%, ⅛-ounce collapsible tubes.
CHLOROMYCETIN OPHTHALMIC, 25 mg. dry powder for solution, individual vials with droppers.

MEDICAMENTA VERA · P & CO.

Parke, Davis & Company
DETROIT, MICHIGAN

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

Volume XXXIX FEBRUARY, 1953 No. 8

CONTENTS

SCIENTIFIC ARTICLES

Leprosy in Florida, Lucius F. Badger, M.D. 573
The Use of Cortisone and ACTH in a Case of Eclampsia, William M. Howdon, M.D., and B. L. Ludwig, M.D. 578
Typhoid Carriers, William A. Walter, M.D. 580
Scientific Critique of Progress in a County Health Unit, Paul W. Hughes, M.D. 582
Our Midwife Problem, Clarence L. Brumback, M.D. 585
Mental Deficiency, William L. Musser, M.D. 589

ABSTRACTS OF MEDICAL ARTICLES

Drs. Peritz Scheinberg, Arthur J. Butt, Nathaniel M. Levin, H. Milton Rogers, James R. Anderson, James B. Glanton, Louis M. Orr, Joseph C. Hayward, W. L. Fitzgerald, M. D. Thomas, Donald W. Smith, James J. Griffitts, and Truett H. Frazier 592

EDITORIALS AND COMMENTARIES

Keeping Eternally Vigilant 599
Patient's Judgment on Medical Emergency Verified 600
Civil Defense Manual on Matching Funds Program 600
Red Cross Finances Gamma Globulin Production 601
Denver A.M.A. Clinical Session 601
"Spirit Incorruptible" 602

GENERAL FEATURES

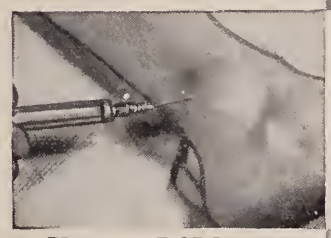
Officers and Committees 596
From Our President 598
Births and Deaths 603
Correspondence 603
New Members 604
State News Items 605
Wanted — For Sale 606
Component Society Notes 607
Obituaries 613
Books Received 617
Schedule of Meetings 621
List of County Medical Societies, Presidents and Secretaries 622

This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

WYDASE HAS MANY IMPORTANT ADVANTAGES
IN EVERYDAY MEDICAL PRACTICE

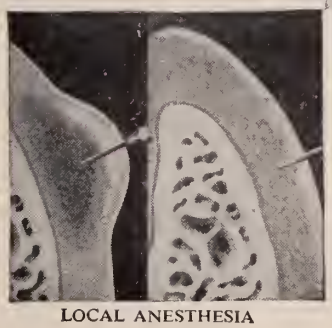
REDUCTION OF
SIMPLE FRACTURES



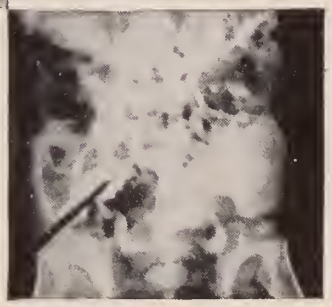
TREATMENT OF SPRAINS

REDUCTION OF HEMATOMAS

HYPODERMOCLYSES



LOCAL ANESTHESIA



HYPODERMAL INJECTION
OF CONTRAST MEDIA

Wydase softens tissue hyaluronic acid. This spreads *injected solutions* and *accumulations* of transudates and blood, facilitating their absorption.

Supplied: Vials of 150 and 1500 TR (turbidity-reducing) units.

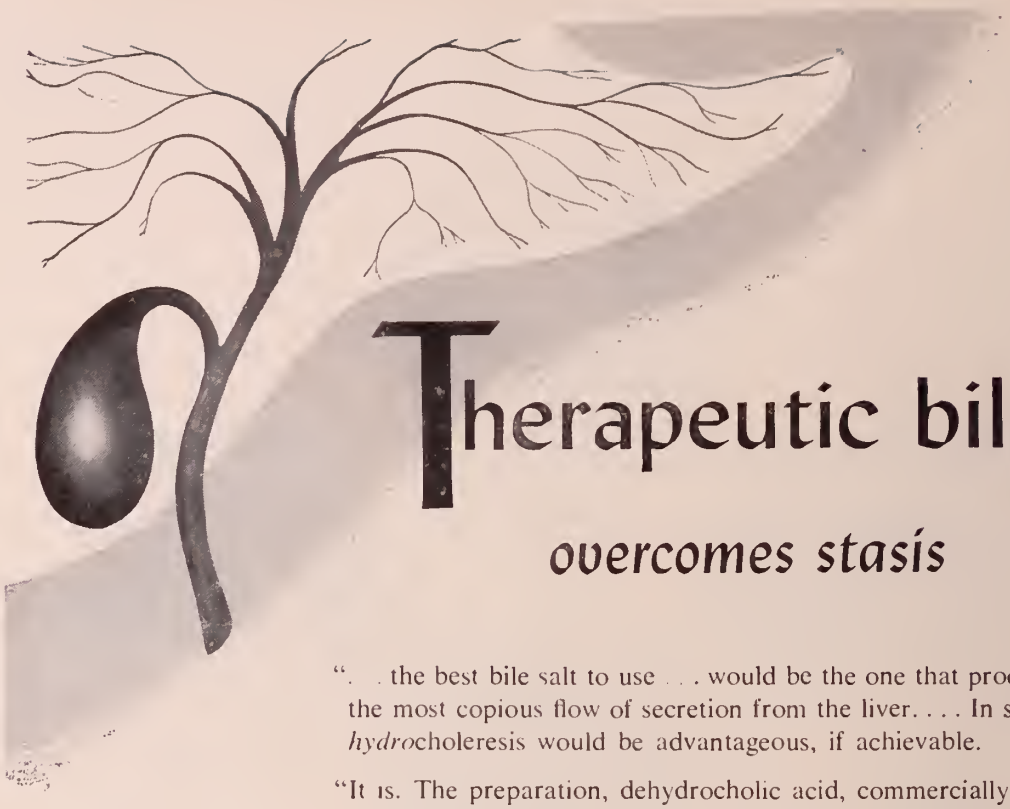
Wyeth®

Lyophilized

Wydase®

Hyaluronidase

***Important Note:** Wydase is now Council-accepted for use in management of renal lithiasis*



Therapeutic bile

overcomes stasis

". . . the best bile salt to use . . . would be the one that produced the most copious flow of secretion from the liver. . . . In short, *hydro*choleresis would be advantageous, if achievable.

"It is. The preparation, dehydrocholic acid, commercially available as Decholin . . . does considerably increase the volume output of a bile of relatively high water content and low viscosity. The drug is not a cholagogue, i.e., it does not promote evacuation of the gallbladder, but it is a good 'flusher'."*

Decholin®

dehydrocholic acid, Ames

*Hydro*choleresis with *Decholin* produces abundant, thin, free-flowing bile—"therapeutic bile." This flushes thickened bile, mucus plugs and debris from the biliary tract.

Decholin Tablets, 3¾ gr. (0.25 Gm.), bottles of 100, 500, 1000 and 5000.

Decholin Sodium (sodium dehydrocholate, *Ames*) 20% aqueous solution, ampuls of 3 cc., 5 cc., and 10 cc.

*Beckman, H.: Pharmacology in Clinical Practice, Philadelphia, W. B. Saunders Company, 1952, p. 361.

Decholin and *Decholin Sodium*, trademarks reg.

AMES
COMPANY, INC., ELKHART, INDIANA
Ames Company of Canada, Ltd., Toronto

46753

"...and be sure to take your VITAMINS!"

When the management of heart disease requires caloric or salt restriction, vitamin intake may be decreased because of unpalatability or inadequate volume of food. A balanced vitamin preparation offers a dependable method for guarding against such an eventuality.

MERCK & CO., Inc., Rahway, N. J.—as a pioneer manufacturer of Vitamins—serves the Medical Profession through the Pharmaceutical Industry.

MERCK

©Merck & Co., Inc.

a broad spectrum dietary supplement

When anorexia interferes with the intake of needed foods in adequate amounts, the resultant effect on the nutritional status of the patient is considerably more apt to involve deficiency in several nutrients than in one particular nutrient. In consequence, unpredictable subclinical deficiency states may arise, which can seriously impede convalescence. Hence when anorexia is present, it is good prophylactic therapy to prescribe a dietary supplement of broad nutrient spectrum, capable of improving the intake of virtually all indispensable nutrients.

The dietary supplement Ovaltine in milk enjoys long-established usage in clinical practice. As is evident from the appended table, it supplies notable amounts of virtually all nutrients known to take part in metabolism. Its biologically complete protein provides an abundance of all the essential amino acids. It is delightfully palatable, easily digested, bland, and well tolerated.

Ovaltine is available in two varieties, plain and chocolate flavored, giving choice according to preference. Serving for serving, both varieties are virtually alike in their wealth of nutrients.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.005 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.15 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.1 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*LIPIDS	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

SULFA*CETAMIDE*

SULFADIAZINE

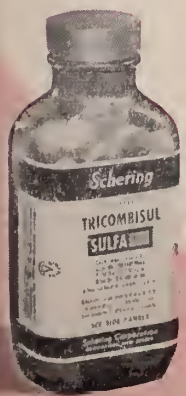
SULFAMERAZINE

the "extra advantage" in this triple sulfonamide is sulfacetamide

TRICOMBISUL® (acet-dia-mer-sulfonamides-Schering) provides not only sulfadiazine and sulfamerazine — standard components of almost all triple sulfonamide mixtures — but also sulfa*cetamide*.

Sulfacetamide brings to the combination extremely high solubility, high bacteriostatic activity, and greater safety for the urinary tract.

TRICOMBISUL



Schering CORPORATION • BLOOMFIELD, N. J.

TRICOMBISUL

SCHERING

DOCTOR . . . now YOU can buy OSMOSE TREATED FENCE POSTS . . . at our CARLOAD PRICE

OSMOSE TREATED FENCE POSTS
— Last 3 to 5 times longer — Resist termites!

Doctors were among the first to appreciate the tremendous savings in time, labor and materials that were made possible by the use of Osmose Treated Fence Posts. Doctors everywhere have also been big boosters for these tougher, longer lasting posts! Because of this, we are making this offer in State Medical Journals throughout the South.

As you may know, Osmose Treated Fence Posts are scientifically treated to make the cellulose fibers in the wood unpalatable to the tiny micro-organisms that normally feed on them. With their food supply cut off, these fungi either die or look elsewhere for sustenance.

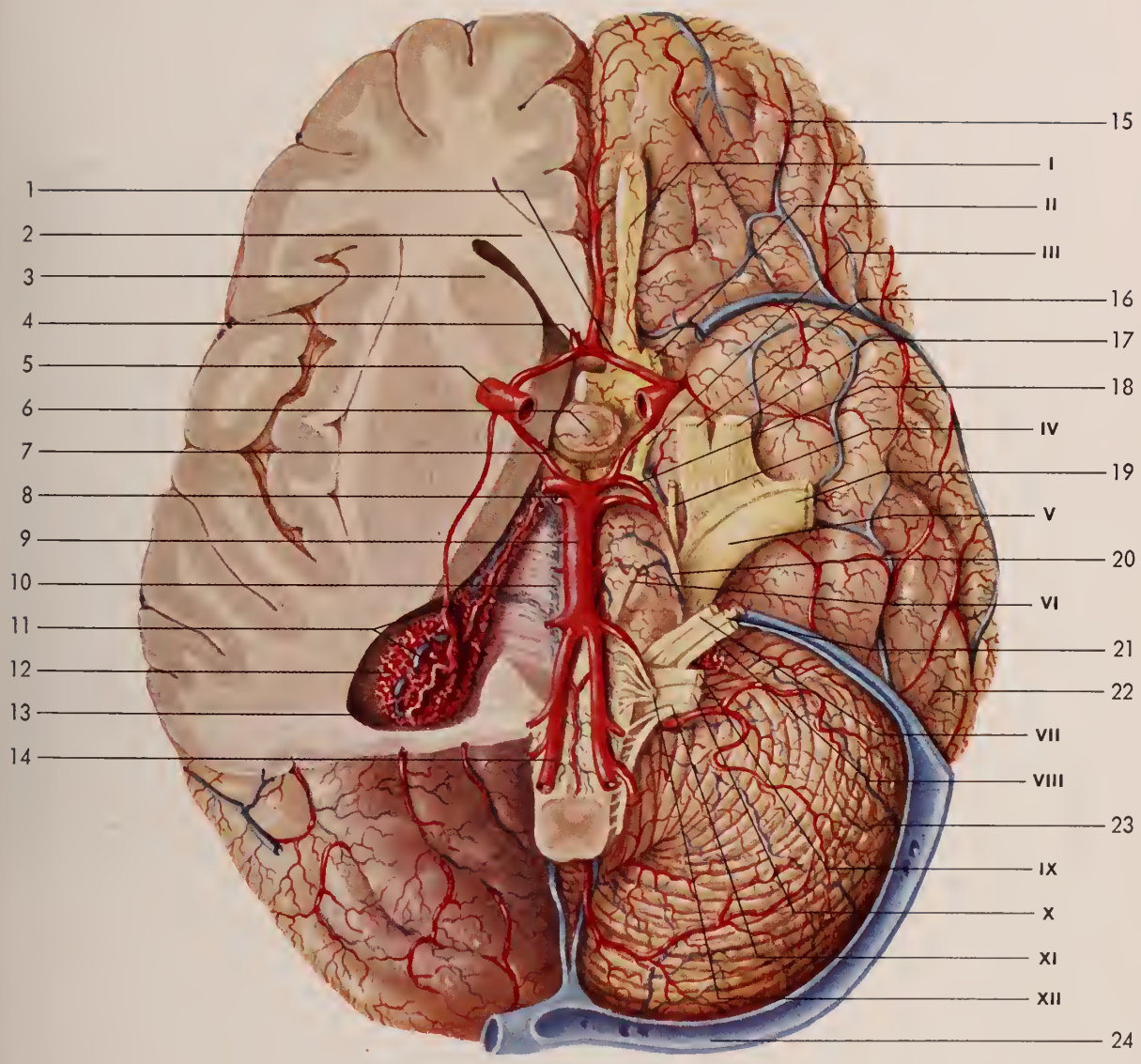
Osmose Treated Fence Posts last up to five times longer, resist the attack of all wood destroying insects and are fire retardant.

If you have a fairly large place, you can easily use 2000 fence posts, which is approximately the number of posts contained in a standard car. If not, perhaps one of your neighbors would welcome the opportunity to share the surplus. Write us today for complete prices and data.

SOUTHERN SALES OFFICES
R. D. DIXON
BOX 298
GRIFFIN, GA.

OSMOSE WOOD PRESERVING CO. Offices and Mills throughout the South

Anatomy *of the* Brain



1. Anterior cerebral artery
2. Trunk of corpus callosum
3. Head of caudate nucleus
4. Anterior communicating artery
5. Middle cerebral artery
6. Hypophysis
7. Posterior communicating artery
8. Superior cerebellar artery
9. Basilar artery
10. Internal cerebral vein
11. Choroid artery and vein
12. Choroid plexus of lateral ventricle
13. Inferior cornu of lateral ventricle
14. Vertebral artery
15. Frontal lobe
16. Ophthalmic nerve
17. Maxillary nerve
18. Posterior cerebral artery
19. Mandibular nerve
20. Pons
21. Intermediate nerve
22. Temporal lobe
23. Cerebellum
24. Left transverse sinus

CRANIAL NERVES

I. Olfactory nerve
II. Optic nerve
III. Oculomotor nerve
IV. Trochlear nerve
V. Trigeminal nerve
VI. Abducens nerve
VII. Facial nerve
VIII. Acoustic nerve
IX. Glossopharyngeal nerve
X. Vagus nerve
XI. Accessory nerve
XII. Hypoglossal nerve

This is one of a series of paintings by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.

Lederle

Aureomycin
HYDROCHLORIDE CRYSTALLINE

in

Intracranial Infections

BECAUSE the urgency of intracranial infections frequently makes it desirable to begin treatment before the causative organism can be determined, there is need for an agent exerting rapid action, which is also effective against a wide range of possible pathogens. Aureomycin—with its ready penetration into the cerebrospinal fluid and its broad antimicrobial spectrum—fills this need pre-eminently well. It is particularly useful in infections resistant to penicillin and streptomycin, and has been used successfully in meningitis caused by *E. coli*, *A. aerogenes*, *Ps. aeruginosa*, *H. influenzae*, staphylococci, pneumococci, *Klebsiella pneumoniae*, *Str. fecalis*, the typhoid bacillus, *Salmonella bareilly*, *Listeria monocytogenes*, and *Moraxella lwoffi*. In meningoencephalitis complicating brucellosis and in encephalitis complicating typhoid, paratyphoid and pertussis infections, aureomycin has proven effective. Impressive clinical improvement has been achieved with aureomycin therapy, after other antibiotics proved unavailing, in infected intracranial hemorrhage, subdural abscess caused by *A. aerogenes*, and brain abscess caused by staphylococci, pneumococci, and *E. coli*.

* * *

PACKAGES: *Capsules:* 50 mg.–Vials of 25 and 100; 100 mg.–Vials of 25 and bottles of 100; 250 mg.–Vials of 16 and bottles of 100. *Ophthalmic Solution:* Vials of 25 mg.; solution prepared by adding 5 cc. distilled water.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
30 ROCKEFELLER PLAZA, NEW YORK 20, N.Y.

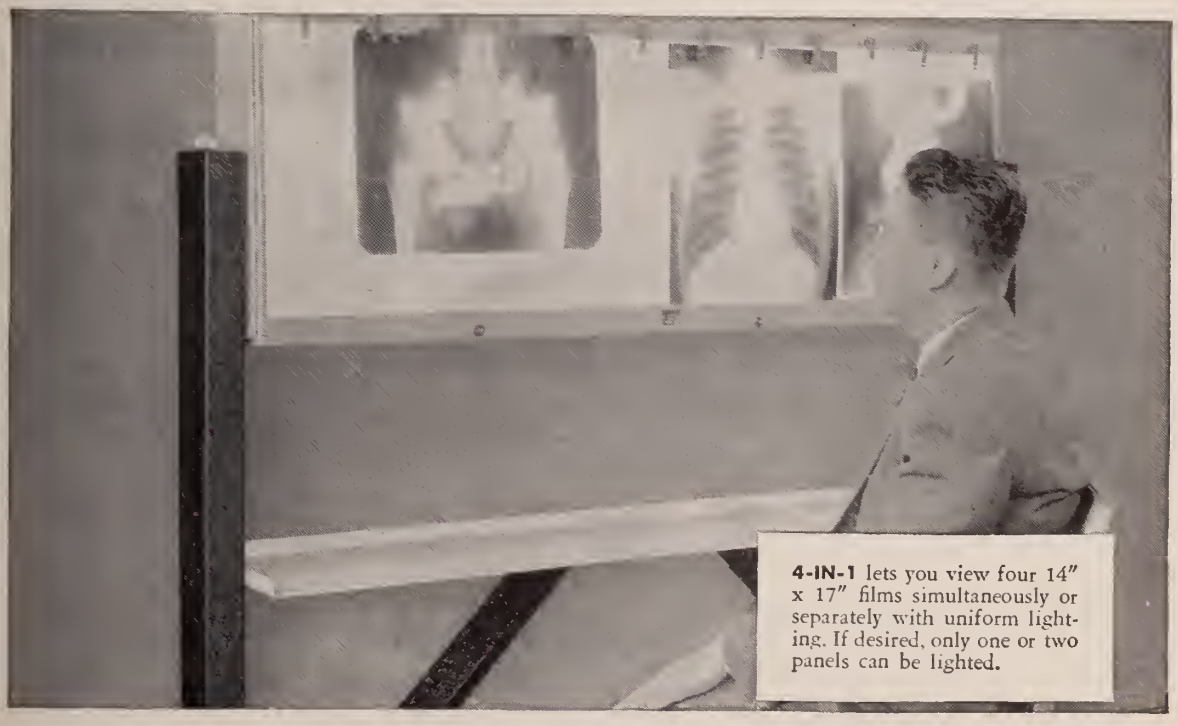
A bibliography of 57 selected references will be mailed on request.

There's a GE viewer just right for you!

CIRCLINE — the best illuminator for general use. Named for the famous GE Circline Lamp that furnishes its top-notch, uniform illumination.

DUOLINE — a lighter, less expensive unit, yet with excellent illumination from two straight General Electric fluorescent lamps.

EXPLOSION-PROOF for operating rooms. Stainless steel throughout and, like the other GE illuminators shown, U/L approved.



4-IN-1 lets you view four 14″ x 17″ films simultaneously or separately with uniform lighting. If desired, only one or two panels can be lighted.

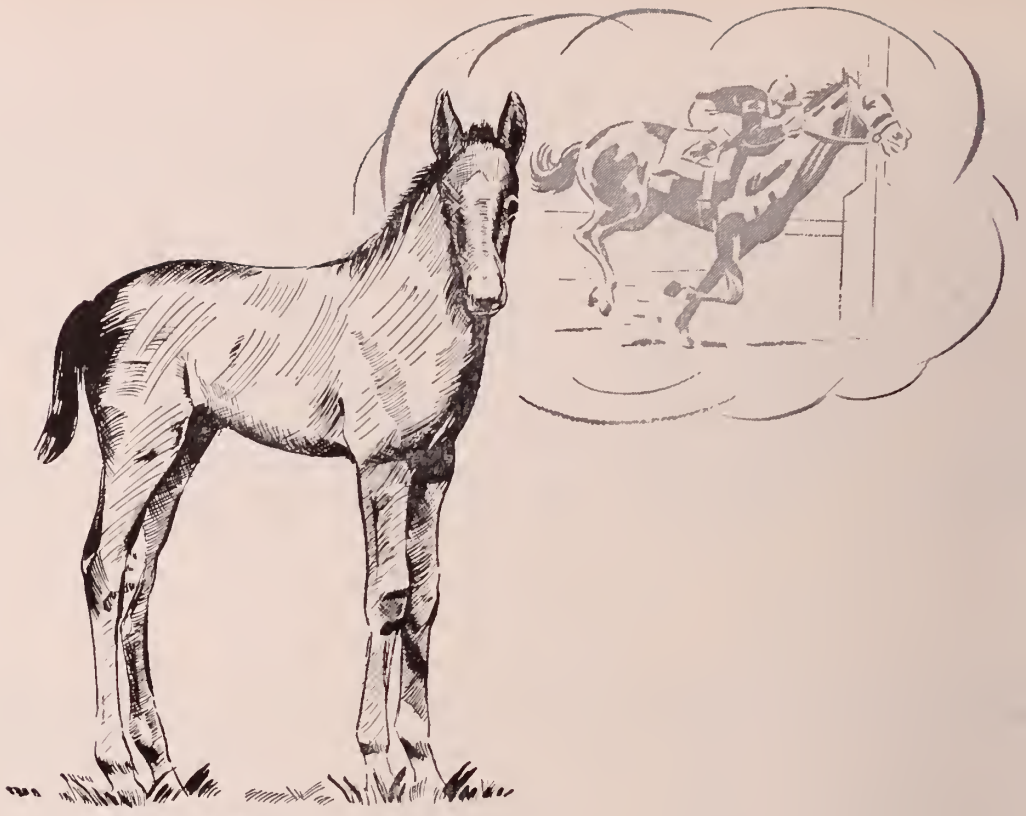
Yes, GE builds illuminators of every type. In addition to the four shown here, you can choose from 70 mm single-frame and stereo viewers . . . 4″ x 5″ and 4″ x 10″ single and orthostereoscopic viewers . . . GE High-Intensity viewers . . . dental viewers. For complete information, see your nearest GE x-ray representative, or write

You can put your confidence in —

GENERAL ELECTRIC

Direct Factory Branches:

JACKSONVILLE — 210 W. Eighth St.
TAMPA — 1009 West Platt St.
MIAMI — 704 S.W. 27th Ave.
BIRMINGHAM — 707 21st St., South



Colt Today

CHAMP TOMORROW

Just as surely as pedigree and training make champions on the race track, so do other factors indicate the future of even small manufacturers of fine pharmaceuticals.

At *thirty years young,* having grown from modest loft quarters to a modern plant and laboratories, we are especially thankful for our *American heritage of free enterprise.*

This and your confidence assure our continued growth.

THE PAUL B. ELDER CO., BRYAN, OHIO
Manufacturers of Fine Pharmaceuticals

MAIL THIS COUPON FOR CATALOG

PAUL B. ELDER COMPANY
BRYAN, OHIO

Please send me your catalog of pharmaceuticals.

Signed_____ M D

Address_____

City_____

*BRAND OF OXYTETRACYCLINE AMPHOTERIC

DON'T MISS Pfizer Spectrum APPEARING REGULARLY IN THE J. A. M. A.

"PREMARIN"®

Highly effective • Well tolerated • Imparts a feeling of well-being

"PREMARIN"

Thousands of physicians prefer "Premarin" for the treatment of the menopause.

"PREMARIN"

Estrogenic Substances (water-soluble)

"PREMARIN"

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

also known as Conjugated Estrogens (equine)

"PREMARIN"

5210

Ayerst®

AYERST, McKENNA & HARRISON Limited • New York, N. Y. • Montreal, Canada

CAMEL

Mild, Flavorful

Pack after pack!

AMERICA'S MOST POPULAR CIGARETTE

How much does it cost, Doctor?

WHEN prescribing an infant feeding formula, you have doubtless often been asked by the mother, "Is it expensive?"

For most families—especially those with children—today's dollar doesn't stretch far. Hence the anxiety of mothers concerning cost.

POWDER and LIQUID

Made from Grade A milk (U. S. Public Health Service Milk Code) which has been modified by replacement of the milk fat with animal and vegetable oils and by the addition of carbohydrates, vitamins and iron.

Sold at an extremely low price, Baker's provides a relatively high protein content (an ample supply of essential amino acids), four sugars, added iron and adequate amounts of vitamins A, D, thiamine, niacin and riboflavin. With Baker's, there's no need to prescribe additional vitamins (except C).

Yet the average cost of feeding most infants on Baker's is only about $1.50 per week. An economical answer to the question, "How much does it cost, doctor?"

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES INC.

Main Office: Cleveland, Ohio
Plant: East Troy, Wisconsin

Division Offices: Atlanta, Dallas, Denver, Greensboro, N. C., Los Angeles, San Francisco, Seattle

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

Upjohn

absorbable
hemostat:

Available in a large variety of sizes and forms, including:

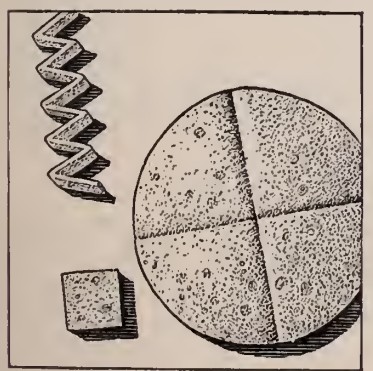
Surgical sponges
Compressed surgical sponges
Dental packs
Gynecologic packs
Nasal packs
Prostatectomy cones
Tumor diagnosis kit

Gelfoam

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Trademark Reg. U.S. Pat. Off. BRAND OF ABSORBABLE GELATIN SPONGE

The Upjohn Company, Kalamazoo, Michigan



Emergency? Not at all. He just wants to be there in case they

call the MEDICAL SUPPLY MAN!"

Exaggerated? Well, yes, a little bit maybe. The Medical Supply Man *is* Johnny-on-the-spot, though, whenever the doctor or hospital needs any one of the 15,000 individual supply items we carry in stock. Or whenever expert repair service on equipment is required. He probably wouldn't come pedalling up on a bicycle without being asked. But he certainly *can* get there in a hurry any time you need him!

So . . . whether it's supplies, new equipment, or a skilled repair job on some of your old equipment . . . you get best service, *fastest* service, when you CALL THE MEDICAL SUPPLY MAN!

HOSPITAL, PHYSICIANS and LABORATORY SUPPLIES & EQUIPMENT

MEDICAL SUPPLY COMPANY

Essentials For Scientific Progress

MIAMI • of JACKSONVILLE • ORLANDO

230 N. E. THIRD ST.
MIAMI 32, FLA.

420 WEST MONROE ST.
JACKSONVILLE 2, FLA.

329 N. ORANGE AVE.
ORLANDO, FLA.

...all the patients who represent the

44 uses for short-acting NEMBUTAL

Case after case from the 593 published reports shows that adjusted doses of short-acting NEMBUTAL can produce any desired degree of cerebral depression—from mild sedation to deep hypnosis.

And with only about half the dosage of many other barbiturates.

Your margin of safety is wide and the duration of effect short. And, since the drug is quickly and completely destroyed in the body, there is little tendency toward cumulative effect or barbiturate hangover.

If you'd like to expand your experience with short-acting NEMBUTAL, write for your copy of the booklet, "*44 Clinical Uses for* NEMBUTAL." Just address a card to Abbott Laboratories, North Chicago, Illinois. Abbott

In equal oral doses, no other barbiturate combines QUICKER, BRIEFER, MORE PROFOUND EFFECT than **Nembutal®**
(PENTOBARBITAL, ABBOTT)

FOR BRIEF AND PROFOUND HYPNOSIS try the 0.1 Gm. (1½-gr.) NEMBUTAL Sodium capsule

1-76

Relaxed but awake

In emotional and nervous disorders, Mebaral exerts its calming influence without excessive hypnotic action.

Mebaral is also a reliable anticonvulsant.

INDICATIONS:

Because of its high degree of sedative effectiveness, Mebaral finds a great field of usefulness in the regulation of agitated, depressed or anxiety states, as well as in convulsive disturbances. Specific disorders in which the calming influence of Mebaral is indicated include neuroses, mild psychoses, nervous symptoms of the menopause, hypertension, hyperthyroidism and epilepsy.

Mebaral®

Tasteless **TABLETS**

Sedative:
32 mg. (½ grain) and new 50 mg. (¾ grain)

Antiepileptic:
0.1 Gm. (1½ grains) and 0.2 Gm. (3 grains)

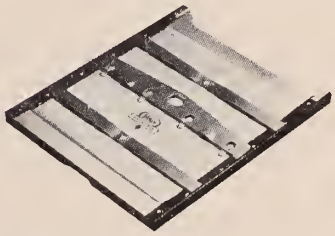
WINTHROP-STEARNS INC. New York 18, N.Y., Windsor, Ont.

Mebaral, trademark reg. U. S. & Canada, brand of mephobarbital

Picker-Polaroid "one minute X-Ray" is now available for CIVILIAN use

You've probably already heard of the "one-minute" Picker-Polaroid radiograph. Introduced a little over a year ago, this dramatic development was immediately accepted by the Armed Services which requisitioned the entire output for military needs. Ever since, we have been struggling to increase production to the point where parallel civilian needs could at least be partly met. That point has now been reached. Limited quantities are becoming available to civilian users.

THE PACKET



THE CASSETTE

The Picker-Polaroid system is an adaptation to radiography of the self-development principle of the Polaroid Land Camera. The whole job takes only a minute . . . can be done in broad daylight . . . needs no darkroom, no solutions, no dryer. It is all incredibly simple and quick: (a) you load the cassette (b) make the exposure (c) put the cassette in the automatic processing box. Wait sixty seconds: open the box and there's your finished radiograph . . . flat, dry, ready for use. Its speed and convenience have already proven invaluable in the operating room for hip-pinning and similar procedures; for emergency hospital admissions, for work with portable and mobile x-ray units.

THE AUTOMATIC PROCESSOR

Since quantities are still limited, those wishing to obtain Picker-Polaroid equipment supplies would do well to communicate at once with either their local Picker office, or with Picker X-Ray Corporation, 25 South Broadway, White Plains, New York.

Picker x-ray POLAROID®

MIAMI 35, FLA., 2759 Coral Way

TAMPA 1, FLA., P. O. Box 3032

JACKSONVILLE, FLA., 422 W. Duval Street

Meat...

and the Therapeutic Value of Adequate Protein

Much evidence can be cited in favor of a high protein intake after surgery, trauma, infection, or burns. In supporting the many anabolic and defense mechanisms of the organism in physiologic stress,[1] high-quality protein—such as that of meat—assumes the status of an important therapeutic agent.[2]

Phagocytic activity,[3] formation of antibodies,[4] and rapid healing of wounds[5] are favorably affected by ample protein nutrition. Remission of peptic ulcer,[6] improved resistance to infectious disease,[4] and maintenance of plasma proteins after surgery[7] are other therapeutic effects attributed to an ample protein intake. In the management of ulcerative colitis, protein represents a primary need.[8] Recent advances in the treatment of extensive burns and of hepatic disease emphasize the value of high protein feedings.[9]

These experimental and clinical findings establish the therapeutic value of high protein intake.[10] To assure therapeutic protein adequacy, the dietary should provide a liberal margin of protein over normal requirements.

Meat is an important source of high-quality protein, containing essential as well as nonessential amino acids. In addition, it supplies significant amounts of B group vitamins and of iron, phosphorus, and other needed minerals.

REFERENCES

1. Ravdin, I. S., and Gimbel, N. S.: Protein Metabolism in Surgical Patients, J.A.M.A. *144*:979 (Nov. 18) 1950.
2. Mann, G. V., and Stare, F. J.: Nutritional Needs in Illness and Disease, in Handbook of Nutrition, American Medical Association, New York, The Blakiston Company, 1951, chap. 17.
3. Mills, C. A., and Cottingham, E.: Phagocytic Activity as Affected by Protein Intake in Heat and Cold, J. Immunol. *47*:503 (Dec.) 1943.
4. Cannon, P. R.: The Importance of Proteins in Resistance to Infection, J.A.M.A. *128*:360 (June 2) 1945.
5. Harvey, S. C., and Howes, E. L.: Effect of High Protein Diet on the Velocity of Growth of Fibroblasts in the Healing Wound, Ann. Surg. *91*:641 (May) 1930.
6. Co Tui, et al.: Hyperalimentation Treatment of Peptic Ulcer with Amino Acids and Dextri-Maltose, Gastroenterology 5:5 (July) 1945.
7. Lund, C. C., and Levenson, S. M.: Protein in Surgery, J.A.M.A. *128*:95 (May 12) 1945.
8. Welsh, C. S.; Adams, M., and Wakefield, E. G.: Metabolic Studies on Chronic Ulcerative Colitis, J. Clin. Investigation *16*:161 (Jan.) 1937.
9. Cannon, P. R., et al.: Recent Advances in Nutrition with Reference to Protein Metabolism, Lawrence, Kansas, University of Kansas Press, 1950.
10. McLester, J. S., and Darby, W. J.: Nutrition and Diet in Health and Disease, ed. 6, Philadelphia, W. B. Saunders Company, 1952, p. 19.

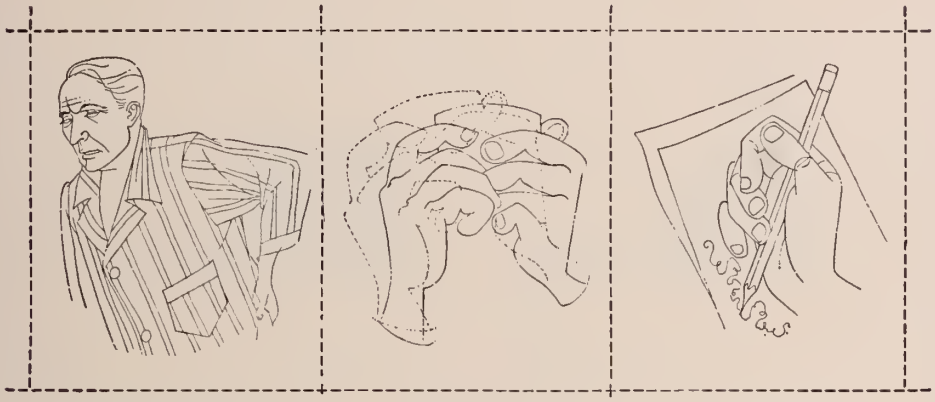
The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

American Meat Institute

Main Office, Chicago...Members Throughout the United States

new uniform oral dosage



in muscle spasm of rheumatic disorders | **in acute alcoholism** | **in certain neurologic disorders**

The new, uniform oral dose for adults is 1-3 grams. This may be repeated 3-5 times per day.

The first dose prescribed should be at the lower end of the recommended dosage range *(an occasional patient may complain of side effects when* large *doses are given at the* start *of Tolserol therapy).* Subsequent doses may be adjusted to the needs of the individual patient. Whenever possible, Tolserol should be given after meals. When Tolserol is given between meals, it is desirable that the patient first drink ⅓ glass of milk or fruit juice.

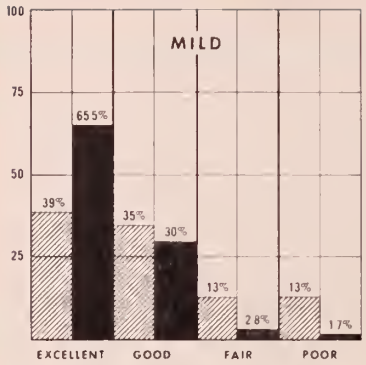
Tolserol

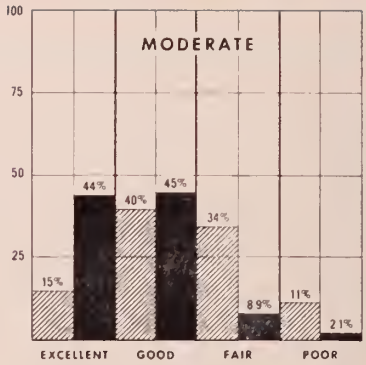
Squibb Mephenesin

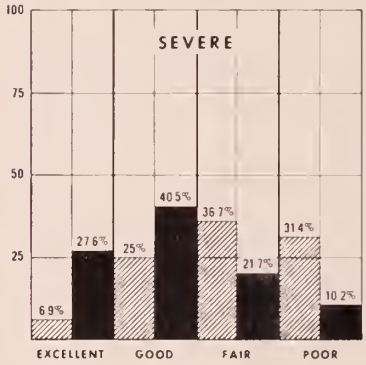
Tablets, 0.5 Gm. and 0.25 Gm., bottles of 100; *Capsules,* 0.25 Gm., bottles of 100; *Elixir,* 0.1 Gm. per cc., pint bottles; *Intravenous Solution,* 20 mg. per cc., 50 cc. and 100 cc. ampuls.

'TOLSEROL' (REG. U. S. PAT. OFF.) IS A TRADEMARK OF E. R. SQUIBB & SONS

SQUIBB







DEGREE OF CONTROL

PRIOR INSULIN THERAPY

NPH INSULIN

Lilly

Better Control for More Diabetics

Striking improvement is shown in the control of 1,281 carefully studied diabetic patients who were given NPH Iletin (Insulin, Lilly) for comparison with prior Insulin management. Of the 1,281 cases, 522 were classified as severe, brittle, or juvenile; 562 as moderate; and only 197 as mild. Although no single modification of Insulin can be expected to meet all the requirements for all patients, results with NPH Insulin appear to be as good as, or often far better than, those obtained by other means.

Graphs reproduced from *Diabetes*, 1:4, p. 293.

Eli Lilly and Company
Indianapolis 6, Indiana, U.S.A.

Simplify diabetic management through improved time action, fewer injections with

NPH Iletin (Insulin, Lilly)

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXIX Jacksonville, Florida, February, 1953 No. 8

Leprosy in Florida

LUCIUS F. BADGER, M.D.
ATLANTA

During this discussion, the extent of the problem of Hansen's disease in the State of Florida will be referred to rather briefly, while major consideration will relate to control.

Problem

Information has been obtained on 133 cases of Hansen's disease recognized among Florida residents during the 30 year period 1921 to 1950. In addition, information has been obtained on 3 cases in which the patients were released from Carville, originally admitted from another state and readmitted from Florida, where they had resided after their release.

One may be assured that the 133 cases do not represent the total number occurring in the state during the period. Undoubtedly there have occurred unrecognized cases and recognized cases that have not come to the attention of officials.

There are, at present in the state, the following classes of cases of Hansen's disease, in some of which the disease is active and infectious: unrecognized; recognized; released from Carville, returned to Florida; absconded from Carville, returned to Florida.

Cases have been recognized in but 12 of the 67 counties of the state. One case, recognized while the patient was in the State Prison in Bradford County, correctly belongs to Monroe County where he resided at the time of onset, although the disease was recognized in the penitentiary. Thus, cases have been recognized in only 11 of the 67 counties during the 30 year period. During the 10 year period from 1941 to 1950, cases have been recognized in but seven of the 67 counties.

Of the total of 133 cases, 113, or 84.9 per cent, were recognized in the three counties of Dade, Hillsborough and Monroe; 43.3 per cent, in Monroe County.

County	Number Recognized 1921-1950	1941-1950
Bradford	1	1
Brevard	1	1
Dade	34	12
Duval	7	1
Hillsborough	20	7
Indian River	2	—
Lee	1	1
Monroe	59	17
Palm Beach	2	—
Pinellas	4	1
Polk	1	—
St. John	1	—
Total	133	41

Hansen's disease in Florida occurs primarily in persons born in the state. Of the 133 cases, the place of birth of the infected person has been recorded in 129, 93, or 72.0 per cent, of whom were born in the state.

Place of Birth	Number
Florida	93
Other states	14
Other countries	22
Unknown	4
Total	133

From the information available it must be assumed that the source of infection in 112, or 86.8 per cent, of the 129 cases with the place of birth recorded has been in Florida and that the prevalence of the disease in the state is about stationary, with a slight downward trend which is evident by the number of cases recognized during the three 10 year periods, 1921-1930, 1931-1940, and 1941-1950. The cases are placed in the period during which the patients were admitted to Carville or during which the diagnosis was made in those cases in which the patient was not admitted to Carville.

Medical Director, United States Public Health Service, Atlanta, Ga.

Read before the Florida Health Officers' Society, Seventh Annual Meeting, Hollywood, April 27, 1952.

Total Number of Cases		
Ten Year Period	Number of Cases	Yearly Average
1921-1930	49	4.9
1931-1940	43	4.3
1941-1950	41	4.1
Total	133	4.4

The trend in the prevalence of cases among Florida-born persons is similar to that of the total number of cases.

Cases in Florida-Born Patients		
Ten Year Period	Number of Cases	Yearly Average
1921-1930	34	3.4
1931-1940	31	3.1
1941-1950	28	2.8
Total	93	3.1

Hansen's Disease in Monroe County

The problem of Hansen's disease in Florida is, for a great part, one of the disease in Monroe County. The significance of the disease in that county to the remainder of the state is evident when the cases are analyzed relative to the residence at the time of onset, residence at the time of recognition and the geographic source of infection in the cases which have occurred in natives of the state.

Residence at the Time of Onset.—The time of the appearance of the first clinical manifestations of the disease is impossible to determine accurately since one is dependent on the opinion or memory of the patient and members of his family and associates. The residence at the time of onset, however, in the majority of the cases can be determined accurately. From the available information it is believed that 57.3 per cent of the total, and 67.8 per cent of the Florida-born persons in whom the disease has been recognized, resided in Monroe County at the time of onset.

Residence at Time of Recognition.—Of the total number of cases, 43.3 per cent of the patients, and of the cases in which the disease occurred in the native-born, 45.1 per cent of the patients were residents of Monroe County at the time of recognition.

Geographic Source of Infection.—In the majority of instances the geographic source of infection can be determined. In some instances, however, a person has lived in two or more endemic areas, or in one or more areas in the state, and the periods of residence in the different areas are not known. It is difficult to determine, definitely, the source of infection in a person who was born in Key West and moved to Miami or other area in the state where he resided at the time of onset. In such cases the source of infection has been considered as probably or possibly in Key West.

Total Number of Cases	Per Cent
Recognized in Monroe County	43.3
Residence in Monroe County at onset	57.3
Source of infection in Monroe County	67.4

Cases in Florida-Born Patients	Per Cent
Recognized in Monroe County	45.1
Residence in Monroe County at onset	67.8
Source of infection in Monroe County	82.7

The importance of the disease in Monroe County to other sections of the state is well illustrated by the experience in Dade County. Twenty-four cases in which the disease occurred in Florida-born persons were recognized in Dade County. Of these, 19, or 79.1 per cent, were born in, or had resided in, Key West before establishing their residence in Dade County.

Hansen's disease in Florida does not constitute a great public health problem. It is principally a problem of the disease among the native-born, and primarily one of the disease in Key West. Hansen's disease is a most important problem as it relates to the afflicted person and to members of his family.

With the problem so small and with an indicated downward trend, one might assume that a well planned and executed control program would hasten the decrease to near extinction, especially among the Florida-born.

Control

Measures instituted for the control of a communicable disease must be directed toward the protection of well persons from sources of in-

fection. The principal measures serving this purpose are: recognition of possible sources — case finding; removal of the sources of infection — by isolation of infectious cases and by therapy, rendering the infectious cases noninfectious; protection of the well by immunization.

With the exception of immunization, the measures for the control of Hansen's disease are no different from those for the control of any other communicable disease. Thus, the principal measures directed toward the control of Hansen's disease are (1) the recognition of the possible source of infection and (2) the protection of the noninfected from the infectious case.

Recognition of the Possible Source of Infection, or Case Finding

A case-finding program should be directed, first, toward members of the household or immediate family; second, toward members of related families; and third, toward other associates or members of the community.

Case Finding Among Members of Household or Immediate Family.—The first logical step in a case-finding program is the examination of members of the immediate family and household. Many are of the impression that there exists a family susceptibility and that a case-finding program is primarily one of examining family and household contacts. If the efforts are confined to the examination of such contacts, many cases will be unrecognized. The accuracy of this statement is suggested by the results obtained from an analysis of the Florida cases.

For the purpose of this discussion, the term "family" designates the immediate family, including only parents and children. Sufficient history as it relates to the family is available on 82 of the 93 cases which have occurred in Florida-born persons. These 82 cases involve 99 families. Of the 99 families, 82, or 82.8 per cent, have been single case, and only 17, or 17.1 per cent, multiple case families.

The situation is not peculiar to Florida, but is universal. In Hawaii, of 404 families, 315, or 77.9 per cent, were single case families. In the Dutch East Indies it has been estimated that in 90 per cent of the families the source of infection was outside the family.

The second step in a case-finding program should be directed toward the members of related families. In Florida in 9 of the 82 cases, or 10.9 per cent, the patient had infected relatives, such as cousins, uncles and aunts, but the disease did not occur among members of the immediate family.

The third step should be directed toward the recognition of cases among nonrelated associates. In 48 of the 82 cases, or 58.5 per cent, there was no instance of the disease among relatives, either in the immediate or in related families.

Thus, of the 82 cases, 25 were preceded by cases among members of the immediate family; 9 were preceded by cases among members of related families, with no cases in the immediate family; and 48, or 58.5 per cent, were preceded by no cases among members of the immediate or related families.

In addition to the examination of the three types of contacts mentioned, physicians and nurses conducting various types of examinations, as school and industrial, and clinics, as prenatal, preschool and tuberculosis, should have in mind constantly the possibility of a case of Hansen's disease occurring among those being examined or observed. Special effort should be directed toward getting contacts of known cases to attend such clinics.

A case-finding program must include the follow-up of cases in which the disease has become arrested and the patient has been released from Carville. In such cases there is a tendency to relapse with the disease again becoming infectious.

Early Recognition.—Early recognition is extremely important, both from the aspect of control and from the welfare of the individual patient. Early recognition and proper disposition in the infectious case decrease the possibility of the patient in that case serving as a source of infection. Early recognition is extremely important in that it will allow for early treatment.

That the disease in the majority of the Florida cases has not been detected early is suggested by the fact that of the 98 patients admitted to Carville, over 50 per cent were admitted after more than five years had elapsed between the onset and admission, and over 25 per cent were admitted after more than 10 years had elapsed. Of those admitted to Carville, 88.8 per cent had lepromatous lesions, and the disease was considered infectious.

Determination of Type. — After Hansen's disease is recognized, it is essential that the type of disease, in each instance, be determined. The proper disposition of a case is related directly to the type of the disease in that case.

Protection of the Well from Infection

Hansen's disease is a communicable disease, transmitted from a person with the disease in infectious form to a well person.

The procedures instituted toward the control of a communicable disease are based on the current information or beliefs relative to the factors influencing the transmission. As the factual knowledge relative to these factors increases, the control procedures may be altered, perhaps relaxed in some respects.

In recent years careful study of large numbers of cases of Hansen's disease has changed the belief relative to certain factors influencing the spread. As a result of this newer knowledge it is evident that, in some respects, the past methods of handling persons afflicted with Hansen's disease were harsh and unjustified. The present attitude of the public and uninformed toward Hansen's disease is the result of these past — in many instances — inhuman practices.

Until comparatively recently leprologists and public health officials recommended that all persons suffering from Hansen's disease be isolated or segregated. At present the consensus of leprologists is that only lepromatous, bacteriologically positive cases are infectious and capable of serving as sources of infection, and need be isolated. Today, the practice is to isolate the patient only in this type of case. Thus, in one respect, following the accumulation of factual evidence, the control practices have been relaxed. As information is accumulated, the control practices, when justified by proved data, may be relaxed further.

There are at present, however, persons who are exerting pressure for further relaxing of the control practices, basing their contention on inaccurate beliefs or unproved facts. A few of these beliefs are:

1. That Hansen's disease is feebly contagious.
2. That, in the newer therapeutic agents, drugs are available which rapidly cause an infectious case to become noninfectious.
3. That the disease is contracted only by prolonged and intimate contact.
4. That adults rarely contract the disease.

Contagiousness of Hansen's Disease. — The statement frequently made, that Hansen's disease is feebly contagious, has led some to urge that all measures of isolation be abolished. This statement is based on clinical cases only. It is based entirely on the number of known contacts who have become infected and in whom clinical manifestations have developed.

In tuberculosis there is available a test, the tuberculin test, which, when giving positive results, indicates infection whether or not clinical or roentgen signs can be detected. There is no such diagnostic test for Hansen's disease. If there were available a similar test for Hansen's disease, one would be able to determine the number of contacts who become infected. Such a test might demonstrate that a large proportion become infected. Contrarily, such a test might show that but a small number of contacts become infected.

With the present knowledge, based on scientific fact, is one justified in stating that the disease is feebly contagious?

Efficacy of the Newer Therapeutic Agents. — There are some, apparently, who recommend relaxation in the control procedures because of the belief that in the sulfone drugs there are available therapeutic agents which are most effective in Hansen's disease and cause rapid reversion from positive to negative — bacteriologically — from infectious to noninfectious stage.

How effective are the sulfone drugs? Members of the Carville staff, who were the first to employ these agents in the treatment of Hansen's disease, have the following to say relative to their effect on the bacteriology:

> During the first year of treatment practically all lepromatous cases remain bacilliferous. During subsequent years of treatment, an ever increasing proportion of persons revert from positive to negative.
>
> Many patients, while improving remarkably from the clinical standpoint, continue to be positive bacterioscopically after several years of sulfone therapy.
>
> It is observed that the most significant drop in numbers of bacilli found in the lesions occurs in the fourth year of treatment.

There is little doubt that the sulfone drugs are the most effective in the treatment of Hansen's disease, but it must be recognized that they do not cause a rapid reversion from positive to negative bacteriology in the lepromatous, infectious cases.

Prolonged and Intimate Contact Necessary. — Some who would relax the control procedures are of the opinion that prolonged and intimate contact with a person having the disease in infectious form is essential to transmission. Is this belief correct?

Intimate contact, probably, is essential; prolonged contact, possibly, is not essential. Perhaps repeated intimate contact is sufficient. Perhaps,

under ideal circumstances, one contact would be sufficient.

Did members of the armed services in whom the disease developed after serving in endemic areas have prolonged intimate contact with persons having the disease in infectious form or did they have repeated intimate contact? Did United States citizens from nonendemic areas of the country, in whom the disease developed after serving as missionaries in endemic countries, have prolonged intimate contact?

That prolonged and intimate contact is not essential for transmission is suggested by the following contact histories obtained from Florida patients, who gave a history of no cases among their relatives:

Visited home of two persons with Hansen's disease and another lived next door.
Visited home of a person with Hansen's disease living across the street.
Knew several persons with Hansen's disease in Key West.
When a child, played with a boy who had Hansen's disease.
As a child, visited two persons with Hansen's disease.
Was a friend of a person with Hansen's disease in Key West.
Knew several persons with Hansen's disease in Key West.
Knew a person with Hansen's disease, but was never a close friend.
When in teens, visited home of a person with Hansen's disease many times.
As a child, associated with a person having Hansen's disease.
Frequently visited two persons with Hansen's disease, often sleeping in same bed with one.
Played with the daughter of a woman suffering from Hansen's disease.
Knew several persons with Hansen's disease in Key West.
Associated with a victim of Hansen's disease for several years.
Knew a person afflicted with Hansen's disease, but was not closely associated.
Was frequently visited by two persons suffering from Hansen's disease.
Was in grade school with a child who had Hansen's disease.
Played with two children who had Hansen's disease.
Had contact with and frequently visited persons with Hansen's disease who were members of husband's congregation.
As an officer of the church, visited the home of a person with Hansen's disease and knew several other persons in church who were afflicted with this disease.

Did these patients have prolonged intimate contact or did they have intermittent intimate contact?

With the present knowledge, based on scientific facts, the type of contact through which transmission may occur is not known.

Adults Rarely Contract Hansen's Disease.—There are some who believe it rare for an adult to contract Hansen's disease. On the basis of this belief, they urge relaxation in control procedures as they relate to adults. Adults do contract the disease, as shown by analysis of the history of patients admitted to Carville, who were born or brought up in nonendemic sections of the United States and who moved to endemic areas in this country or endemic areas in other countries, or who served as missionaries or members of the armed services in endemic areas. Most of these were born and spent their early life in Northern states.

Ages at which these patients entered endemic areas:

Age Group	Number
0-9	16
10-19	8
20-29	35
30-39	11
40-49	6
50-59	1
Total	77

Over 10 years of age	61	79.2 per cent
Over 20 years of age	53	68.8 per cent
Over 30 years of age	18	23.3 per cent
Over 40 years of age	7	9.0 per cent

In instituting control procedures the health authorities must be guided by proved facts relating to the factors influencing the transmission or by beliefs which, to the best of current knowledge, appear to be correct. As factual knowledge increases, changes in the procedures should be inaugurated. Such increased knowledge can be obtained only by the investigation and study of each case.

With the present knowledge, is one justified in further relaxing the control procedures at this time? I am sure that no one afflicted with Hansen's disease desires a relaxation in procedures which will cause members of his family, friends or others to become infected. I am convinced that no health official would like to be responsible for contraction of the disease by anyone. I, personally, do not wish, through recommendations of changes of control procedures, to be responsible for the infection of even one person. I would take the same attitude toward tuberculosis.

A control program, to be effective, must have the cooperation of the patients and members of their families. It will continue to be difficult to obtain the desired cooperation until the public

has been enlightened to the real nature of the disease and the current, accepted beliefs relative to its transmission. This cooperation will not be obtained until the public regards the disease simply as a communicable disease, transmitted from person to person by contact. The public must be informed that not in all cases of Hansen's disease is the patient considered as a possible source of infection and that persons with noninfectious types may continue a normal existence, including treatment at general clinics and in general hospitals.

The patient himself and the members of his family must be instructed relative to the various factors of the disease. Such instruction will assure better cooperation on their part. Through the assistance of the medical social service organization, in those instances in which the bread winner or the mother is involved, better cooperation of the patient and his family will be obtained.

Through the desired cooperation of all involved, the highly important, early recognition of the disease will result.

Summary

Hansen's disease is not a great public health problem in Florida. The problem, for the most part, is one of the disease in Key West. The prevalence of the disease is about stationary, with a slight downward trend indicated. With the problem so small and with an indicated downward trend, one might assume that a well planned and executed control program would hasten the decrease to near extinction, especially among the Florida-born.

50 Seventh Street Northeast.

The Use of Cortisone and ACTH In a Case of Eclampsia

WILLIAM M. HOWDON, M.D.
AND
B. L. LUDWIG, M.D.
MIAMI

A case is reported in which pregnancy was complicated by severe postpartum eclampsia. It is herewith presented to report: (1) the effect of cortisone and ACTH in an eclamptic patient who was considered refractory to our usual routine; and (2) the sequelae.

Report of Case

Mrs. C. J., a 25 year old Negro, was gravida II, para I. All past history was noncontributory. Two years before, the patient had spontaneously delivered a living, full term child. The antepartum, intrapartum and postpartum course was normal.

There was a history of menstruation at regular 28 day intervals with the period lasting four to five days. The last menstrual period began on Jan. 15, 1950. The expected date of confinement was October 22.

On May 30, at 16 weeks' gestation, the weight was 213 pounds, and the blood pressure was 110 systolic and 70 diastolic. On October 7, the weight was 221 pounds, and the blood pressure was 110 systolic and 80 diastolic. There was a gain in weight of 8 pounds in four days. Urinalysis was not made. Seventeen days later, on October 24, the patient spontaneously delivered a full term living male child at home. The physician described the labor as uneventful.

On the first postpartum day there developed a severe headache which progressed, and on the second postpartum day she was sent to this hospital.

When she was admitted to the emergency room, the blood pressure was 160 systolic and 110 diastolic. One plus edema was present in the extremities and face; no visual disturbance was elicited. Urinalysis showed 2 plus albumin. She was sent home, and a regimen of bed rest, barbiturates, and a high protein, salt-free diet was prescribed.

Twenty-four hours later the headache became more severe. She complained of blurring of vision, nausea and vomiting, and epigastric pain, followed by a convulsive seizure.

On admission to the hospital she appeared to be in a toxic state of considerable degree, although conscious and oriented. The blood pressure was 252 systolic and 160 diastolic. Two plus edema of the extremities was present, along with moderate facial edema. The eyegrounds displayed no hemorrhages or exudates. Laboratory findings were: urinalysis, 2 plus albumin with microscopic examination giving negative results; hemoglobin 70 per cent (10.8 Gm.); red blood cells 3,410,000; hematocrit value 36 mm.; nonprotein nitrogen 30 mg.; total serum chlorides 620 mg. per hundred cubic centimeters; and albumin-globulin ratio 1 to 1. An electrocardiogram showed changes indicative of myocardial impairment on a toxic basis. Our eclamptic routine was instituted (barbiturates and magnesium sulfate solution intravenously, 500 cc. of whole blood and 500 cc. of plasma, nasal oxygen, et cetera).

Several hours later there developed a series of tonic-clonic convulsions, although the patient appeared to be well sedated. The condition became critical, with temperature 104.4 F., pulse 116, respirations 20, and blood pressure 180 systolic and 110 diastolic. Twenty-four hours after admission the condition became progressively worse, with temperature 104 F., pulse 140, respirations 40, and

From the Department of Obstetrics and Gynecology, Jackson Memorial Hospital, Miami.

Cheyne-Stokes respiration was present. The blood pressure was 108 systolic and 80 diastolic, comparable to shock in a patient with previously existing hypertension. It was thought that the patient was moribund.

We decided to administer cortisone, 100 mg. every eight hours for two days, 100 mg. every 12 hours for two days, and 100 mg. for one day, a total of 1,100 mg. over a period of five days. To help maintain the falling blood pressure, 1,500 cc. of whole blood was given intravenously. An intragastric drip of a special protein solution was continued.[1-4] The amount given daily was equal to the urinary output of the preceding 24 hours plus the calculated insensible fluid loss. Under cortisone therapy the condition varied as follows:

	Temperature	Pulse	Respirations	Blood Pressure	Urinary Output
After 24 hours	102.2	112	34	152/110	750 cc.
After 48 hours	104	160	28	160/110	1,070 cc.
After 72 hours	104	124	36	170/108	1,225 cc.

At no time was there laboratory evidence of hypernatremia, hyperchloremia, or hypopotassemia.

During this time the patient required no sedation as she was comatose. One week after cortisone therapy she was fully conscious but noisy and disoriented.

Daily circulating eosinophil counts during administration of cortisone revealed no eosinophils per cubic millimeter. We interpreted this as a good response.

A neurologic examination and spinal fluid analysis at this time gave essentially negative results. A diagnosis of schizophrenia was made, because of a sudden personality change that was believed to be present prior to the administration of cortisone.

One week after cortisone therapy, treatment with ACTH was started. One hundred milligrams was given daily for three days and 25 mg. twice a day for seven days. The patient was free of all clinical edema before the administration of ACTH was begun, and none reappeared while this drug was used. There was no laboratory or clinical evidence of hyperchloremia, hypernatremia, or hypopotassemia. The blood pressure was constant (150/90), and the urinary output remained within normal limits.

The total circulating eosinophil response to ACTH was poor.

One month from the date of admission the patient was still confused and disoriented. On discharge, the blood pressure was 154 systolic and 98 diastolic; temperature 99 F.; pulse 82; respirations 20; hemoglobin 85 per cent (13.4 Gm.); red blood cells 5,130,000; nonprotein nitrogen 25.4 mg.; total serum chlorides 615 mg. and total serum protein 7:37 Gm. per hundred cubic centimeters. She was transferred to a mental institution and received, with other therapy, a series of electric shock treatments. The mental condition has remained unchanged during the last 10 months of therapy. The blood pressure has remained slightly elevated, and kidney function tests have given negative results for residual renal disease.

A diagnosis of severe schizophrenia, hebephrenic in type, was made. The prognosis was regarded as poor.

Discussion

The signs and symptoms produced by overdosage with mineral corticoids, when compared with comparable findings in eclamptic patients, suggest that eclampsia may be a disease of adaptation.[5]

The treatment of eclamptic patients with adrenal cortical extracts or desoxycorticosterone has been advocated in the past. Its effectiveness in many cases has been doubtful, and in most cases it is contraindicated.

In the event that a person is continuously exposed to stress, as in pregnancy, the resulting general adaptation syndrome of Selye evolves in three distinct stages: (1) the alarm reaction; (2) the stage of resistance; and (3) the stage of exhaustion. We have classified our patient in the third stage at the time cortisone was given. This stage also represents the sum of all nonspecific systemic reactions which had developed as a result of prolonged exposure to stress, to which adaptation for a considerable period of time had developed but could no longer be maintained. It is our belief that cortisone is contraindicated except in the stage of exhaustion.

The clinical and physiologic improvement in our case, following the administration of cortisone to a moribund patient when all previous treatment had failed, indicates in our opinion that this therapy is of merit and in this instance was responsible for the recovery of the patient.

Lack of evidence of eosinophil response indicates that the adrenal cortex was not responsive to ACTH in the concentration and the amount given.

The emotional disturbances which occur at the time of, and following, the administration of cortisone and/or ACTH usually represent exaggeration of the patient's underlying mental tendencies. Since approximately 50 per cent of all schizophrenics do not respond to therapy, it behooves us to be most careful in the treatment with corticosteroids of those patients who have a history of mental instability.

Summary

It is our impression, following the administration of cortisone and ACTH in moribund eclamptic patients, that cortisone alone has a definite beneficial effect when given during the stage of adrenal exhaustion. Careful observations from the laboratory and clinical standpoints must be made. Maintenance of electrolyte and fluid balance at all times is most important.

No conclusion may be drawn on insufficient data. Our experience in the case reported and with other cases encourages us to consider the use of cortisone in cases of eclampsia, in the stage of circulatory collapse.

References

1. Bryant, H. H.; Griffitts, J. J., and Smith, D. W.: Prolonged Drip Feeding, Jackson Memorial Hospital Bulletin, Vol. 6 (Jan.) 1952.
2. Elman, R.: Time Factor in Retention of Nitrogen After Intravenous Injection of Mixture of Amino-Acids, Proc. Soc. Exper. Biol. & Med. 40:484-487 (March) 1939.
3. Cox, W. M., Jr., and Mueller, A. J.: Serum Albumin Regeneration as Effected by Intravenously and Orally Administered Protein Hydrolysates, J. Clin. Investigation 23:875-879 (Nov.) 1944.
4. Cannon, P. R.; Steffee, C. H.; Frazier, L. E.; Rowley, D. A., and Stepto, R. C.: The Influence of Time of Ingestion of Essential Amino Acids upon Utilization in Tissue Synthesis, Federation Proc. 6:390, 1947.
5. Selye, H.: The Physiology and Pathology of Exposure to Stress, Montreal, Canada, Acta, Inc., 1950; Annual Report on Stress, Montreal, Canada, Acta, Inc., 1951; The Story of the Adaptation Syndrome, Montreal, Canada, Acta, Inc., 1952.

1002 Huntington Building.

Typhoid Carriers

WILLIAM A. WALTER, M.D.
JACKSONVILLE

As the incidence of typhoid fever continues to show a downward trend, water-borne, milk-borne and other alimentary-borne epidemics of this disease have practically disappeared in Florida. Nevertheless, in many areas there are foci of infection which come to the attention of the State Board of Health by the occurrence of sporadic cases. Common vehicle epidemics have been practically eliminated by the tremendous improvements made in general sanitation, but isolated, sporadic cases are still with us. These cases are often caused by chronic carriers of Salmonella typhosa. It is obvious therefore that detection and supervision of carriers are becoming increasingly important.

It is equally obvious that only a small percentage of these carriers are known to public health authorities and that their adequate supervision is extremely difficult, if not impossible.

The principal methods for the detection of carriers are through follow-up observations of cases of typhoid fever and through epidemiologic investigations of these cases. Only occasionally are carriers brought to light by routine, periodic stool examinations of persons applying for food handlers' cards. In Florida during 1951, 13 new carriers were added to our roster. Eight of these were discovered by means of epidemiologic investigations, and 5 were previously known carriers who moved to Florida from other states. Thus far in 1952, 1 new carrier has been added, and he was discovered by means of a routine food handlers' examination.

In most of the outbreaks of typhoid fever which have been traced to carriers, they turn out to be persons who discharge typhoid bacilli in the feces rather than in the urine. Also, some carriers are more likely to spread disease than others because of variations in personal habits, or increased opportunity of infecting food and drink, or differences in the quantity and virulence of organisms discharged. In addition, carriers are often intermittent or irregular in the elimination of typhoid bacilli. A typhoid carrier employed in a dairy, or one who is a cook, waiter or nurse, is a special menace. The amount of harm which one carrier can cause is amazing, as witnessed by the case of Mary Mallon. In this person, employed by a family as a cook, typhoid fever developed in 1901. One month later typhoid fever developed in the laundress of this family.

In 1902 Mary was employed as a cook in another household, and within a short period of time the disease developed in 7 members of the household. In 1904, she again changed jobs, and within three weeks after her arrival 4 servants in this home were attacked. Two years later, after she got employment in another home, in 6 of 11 members of the family the disease developed. At this time the cook was first suspected. During the five year period she is known to have been the cause of 26 cases of typhoid fever. She was then hospitalized by the New York Department of Health for some three years.

In 1914 she was engaged as a cook in the Sloane Hospital for women in New York. Within two months an outbreak of typhoid occurred involving 25 cases. The cook was suspected, but she left the premises on a few hours leave and did not return or leave her address. She was, however, located by the health department under an assumed name, and on investigation her identity was established as the famous "Typhoid Mary."

In approximately 50 per cent of typhoid cases, the patients continue to discharge typhoid bacilli in the feces for three weeks after the onset of the disease, and about 5 per cent are still discharging the organisms after 11 to 13 weeks. At the end of five months, the figure has decreased to about 3 per cent. Persons in this group are known as convalescent carriers. A chronic carrier is a person who has not suffered from typhoid fever

Director, Division of Venereal Disease Control, Florida State Board of Health.

Read before the Florida Health Officers' Society, Seventh Annual Meeting, Hollywood, April 27, 1952.

within the previous 12 months and who discharges typhoid bacilli.

Older persons are more likely to become carriers than children. The highest frequency (about 15 per cent) occurs in women aged 40 to 49 years.

Detection of Carriers

If it is true then that the typhoid problem has largely resolved itself into a typhoid carrier problem, how are we to detect carriers so that they may be placed under adequate supervision?

The isolation of Salmonella typhosa is still the only method of making an accurate determination of the carrier state. This procedure, however, remains an expensive and often uncertain method. Associated with the difficulties encountered is the phenomenon of intermittent excretion of bacilli. The existence of the carrier state, therefore, cannot be denied on the evidence of one or two fecal specimens, examination of which gives negative results.

Because of the limitations of cultural methods of detection, many workers have explored the use of serologic methods to be employed as screening tests. The use of O and H agglutinins is not practical because a rather high proportion of the serums of normal persons contains O and H agglutinins.

In 1934 Felix and Pitt described a hitherto unknown antigen of S. typhosa. They showed that this antigen is related to the virulence of the organism, and Felix christened it the Vi antigen. Subsequently, it was shown by Felix and others that in chronic carriers the frequency of a positive Vi reaction in the serum was especially high.

Many workers, however, have had serious reservations concerning the specificity and sensitivity of the reaction and the stability of the Vi antigen. Although it has always been considered a useful test, it has fallen into disuse because of certain technical limitations.

In 1951 Saint-Martin and others in Montreal described a Vi agglutination test which they believed presented unusual qualities of antigenic stability, specificity and sensitivity. Using their technics and a glycerolated Vi antigen, they examined 10,912 serums from October 1946 to August 1950. Negative results were obtained in 98.8 per cent of normal serums and in 98.2 per cent of serums from persons immunized against typhoid. In 80 per cent of 530 clinical cases of typhoid, a positive Vi reaction was observed. The serums of 26 bacteriologically proved carriers were found to contain Vi antibodies.

In September of 1951 Dr. A. V. Hardy, Director of the Bureau of Laboratories, Florida State Board of Health, made provisions for performing this test. Mrs. Galton of this Bureau set up the tests. There were many technical problems which had to be worked out, but eventually the laboratory personnel believed that these had been solved. In order to obtain serums for testing, a letter was sent to each health officer in whose county there was a known or suspected typhoid carrier. In this letter it was requested that a blood specimen be sent to the laboratory for testing. By this method 16 specimens were obtained and tested. Fourteen, or 87.5 per cent, gave a positive Vi reaction. Although this is only a crude and small sample, it was thought that the technical limitations of the test had been overcome and that the procedure could be made available to health officers on a request basis.

The presence of Vi agglutinins is not diagnostic of the carrier state; however, it is clear that the serum of probably over 90 per cent of chronic typhoid carriers contains Vi agglutinins. We, therefore, are presenting this test to you and recommending it as an efficient screening test which, if giving positive results, should be followed by numerous examinations of urine and feces in an effort to isolate S. typhosa.

References

Rosenau, M. J.: Preventive Medicine and Hygiene, ed. 7, edited by K. F. Maxcy, New York, Appleton-Century-Crofts, Inc., 1951, pp. 180-206.

Saint-Martin, M., and Desranleau, J. M.: Results Obtained with a Glycerolated Vi Antigen in the Detection of Chronic Typhoid Carriers, Am. J. Pub. Health 41:678-692 (June) 1951.

Topley, W. W. C., and Wilson, G. S.: Principles of Bacteriology and Immunity, ed. 3, revised by G. S. Wilson and A. A. Miles, Baltimore, The Williams & Wilkins Company, 1951, vol. 1, pp. 702-745.

1217 Pearl Street.

Seventy-Ninth Annual Convention
Florida Medical Association
Hollywood, April 26-29, 1953

Scientific Critique of Progress in A County Health Unit

PAUL W. HUGHES, M.D.
FORT LAUDERDALE

Increased efforts are being made to evaluate health departments and areas of protection with regard to "How much health protection do we have? What do we need?" Coincidental with such attempts, it might be a good idea to evaluate the current status of diseases involved directly in health department work by means of known statistics and some available simple indices.

As public health is both an art and a science just as the practice of medicine is, the most important factor is the confidence and liaison of the local health department with the patient — the citizenry. This can most likely be best evaluated by the introspections of a person outside of the county in so far as determining the extent to which the Health Department has participated in planning and consultation with community official and nonofficial agencies relevant to health problems and projects.

In the statistical or scientific approach one may peruse monthly activity reports, morbidity reports, mortality reports, reports of days missed from school or work, insurance reports and evaluation studies, but none of these appears to be basic enough to enable one to gain a knowledge of the true status of some diseases with which the Health Department is concerned. For example, what is the nutritional status of the children? Is it improving or not? Are dental caries increasing in rate? Are more or fewer children being protected against diphtheria currently? Is sanitation getting worse or better? Is mental disease increasing in children? Is syphilis on the way out? What about the endemicity of tuberculosis in so far as increasing or decreasing is concerned? Is the dog population protected against rabies this year more or less than last year? These and many other questions can be asked, but not usually answered except by finding special indices.

An index for each should be simple to obtain and definitive. In an attempt to answer these questions, examples are discussed in the following material.

Immunization

Twenty per cent of the children currently 18 months old are checked via records or nursing visits to determine their immunization status. Results so far are as follows:

Children Born	Smallpox Vaccine Per Cent	Diphtheria Per Cent	Pertussis Per Cent	Tetanus Per Cent
Nov. 1949	17	43	43	43
Dec. 1949	22	50	50	50
Jan. 1950	7	35	35	35
Feb. 1950	19	29	29	30
Sept. 1950	18	36	36	36

RABIES IMMUNIZATION OF DOGS. — Each month each veterinarian in private practice gives the Health Department a report of the number of dogs immunized against rabies. It is expected that the dog population increases with the human population. Broward County's population is increasing at the rate of 12 per cent per annum. The number of dogs protected against rabies in 1950 was 2,884; in 1951, 3,375. These figures show a 17 per cent increase in the number of dog immunizations.

Nutrition

With the use of a standard height-weight-age chart, the per cent of underweight children in each elementary school can be determined year after year. Specific data are given in the 1951 Broward County Annual Report. An over-all comparison of the nutrition is as follows:

	1949	1950	1951
Underweight	20%	11%	13%

If one considers anemia as present in those having a hemoglobin estimation of less than 10 Gm., studies can be made in the schools to determine the extent of anemia and progress in this field. In one Negro school, the results of a two year study were as follows:

Director, Broward County Health Department.

Read before the Florida Health Officers' Society, Seventh Annual Meeting, Hollywood, April 27, 1952.

Year	Children Tested	Number Anemic
1949	44	4 9%
1951	44	5 10%

Parasites

In Florida probably the best index of primordial sanitation is the presence or absence of such parasites as ascaris and hookworm. The individual schools representing certain areas showed a definite pattern of infestation. In the city schools few or none of these parasites were noted. In the fringe areas about the cities light infestation was present. The rural areas showed heavy infestation. This pattern remarkably reflects the knowledge of the areas of good, fair and poor sanitation respectively in Broward County. Details are given in the Broward County 1950 Annual Report. Figures showing the infestation of the school children in the respective areas as studied in two respective years are presented in table 1. Over 3,000 stool analyses were performed, and at least 20 per cent of each student body was tested.

Table 1.—Parasites in School Children in Broward County

Schools	1950 Ascaris Per Cent	1950 Hookworm Per Cent	1951 Ascaris Per Cent	1951 Hookworm Per Cent
Hammondville (c)	33	0	50	7
Migratory Camp (c)	33	2	31	2
Oakland Park (c)	46	1	35	7
Braithwaite (c)	30	1	43	1
Pompano (c)	33	2	33	3
Davie (c)	33	22	68	9
Dillard (c)	46	3	46	1
Attucks (c)	20	1	30	1
Lanier (c)	13	1	21	3
Carvers Ranch (c)	20	10	5	2
Oakland Park (w)	0	40	1	3
Wilton Manor (w)			0	1
Stranahan (w)			1	3
Deerfield (w)	4	12	4	7
Davie (w)	2	35	4	19
Riverland (w)			3	6
Hollywood Hills (w)	2	11	2	4
West Hollywood (w)	4	9	7	7

Mental Health Study

Teachers were asked how many of their students they would refer to a mental hygiene clinic if one were available, the children so referred being considered mildly or severely maladjusted. The following represents the resulting tabulation:

Enrolment Number of Pupils		Considered Mildly Maladjusted Number	Considered Mildly Maladjusted Per Cent	Considered Severely Maladjusted Number	Considered Severely Maladjusted Per Cent
White	10,294	364	3.6	120	1.1
Negro	4,751	150	3.2	38	0.8
Total	15,045	514	3.4	158	1
		Total 672	4		

This compilation may prove to be interesting if made every year or two and may possibly give an index of the mental health of the county's school children.

Preschool Children

The 5-6 year age group provides an excellent and accurate source of information relevant to nutrition, dental caries and parasites. Results of surveys were as follows:

	1950	1951
Number of children examined	662	709
Underweight	27%	11%
Dental caries	37%	21%
Hookworm	9%	2%
Ascaris	31%	20%

Syphilis

The endemicity of syphilis is particularly difficult to evaluate from the viewpoint of morbidity or mortality statistics. First grade Negro children were tested with the following results:

	1949	1950	1951
Number examined	270	348	314
Number, positive reaction	8	10	3
Per cent, positive reaction	3	3	1

In the background all babies three months to six years of age whose mothers had had a positive reaction to a blood test during pregnancy are blood-tested. During 1951, 141 tests were performed, showing in 4, or 2.8 per cent, positive results for syphilis. This index will be continued year to year.

A blood-testing program of twelfth grade Negro children was begun. Out of 78 twelfth grade Negro students, 1, or 1 per cent, was noted to have syphilis. This index of the endemicity of acquired syphilis will be continued yearly

A rich reservoir of syphilis was found in the county jail population. Most of the inmates stay only a short time, but are almost always (80 per cent) tested before they leave. There were 767 blood tests performed. The results in 154, or 20 per cent, were positive for syphilis. For this segment of the population the accruing yearly statistics will be most interesting.

Tuberculosis

The most interesting figures for tuberculosis were obtained in two mass surveys. In 1948, 37 cases of tuberculosis were discovered upon review of 14,000 roentgenograms of the chest. In 1951, only 13 cases were found in reviewing the same number of roentgenograms.

To check further into the endemicity of tuberculosis, comparative skin tests are being made on first graders. The present aim of tuberculosis control appears to be to have a population react-

ing negatively to the skin test for tuberculosis. The new first graders each year should represent in the statistics acquired the increase or decrease of tuberculosis in a given area.

Diabetes

Among 2,716 persons tested in 1951 via blood test, 42 new cases of diabetes were discovered and 70 known cases reaffirmed. Future surveys should throw some light as to the increase or decrease of this disease in the county population and also the relative effectiveness of health education in this field.

Maternal and Infant Mortality

The figures readily available concerning maternal and infant deaths (except stillbirths) are, of course, reliable. Comparative county and state figures are as follows:

	1950		1951		1951 State	
	Number	Rate	Number	Rate	Number	Rate
Infant						
Deaths	72	38.0	82	32.6	2,308	32.7
Maternal						
Deaths	4	2.1	3	1.2	88	1.3

Rates are per thousand live births.

Table 2.—Underweight School Children in Broward County

Schools	1949 Per Cent	1950 Per Cent	1951 Per Cent
Hollywood Central (w)	17	1	6
Lanier (c)	41	3	27
Little Flower (w)	11	4	11
St. Anthony's (w)	15	4	14
Davie (c)	63	4	8
Hallandale (w)	23	4	10
Pompano (c)	45	7	12
Westside (w)	28	8	15
Braithwaite (c)		8	14
Dania (w)	8	10	10
Pompano (w)	17	10	12
Davie (w)	27	11	24
Southside (w)	19	12	17
Naval Air Station (w)			
Northside (w)	16	14	11
Oakland Park (w)	25	13	12
Carver's Ranch (c)	50	13	10
Riverland (w)	43	13	13
Eastside (w)	16	14	15
Hollywood Hills (w)	23	17	7
Oakland Park (c)			
Deerfield (w)	36	18	19
Attucks (c)	27	18	26
Pompano Migratory Camp (c)		20	15
Dillard Elementary (c)		22	8
Hammondville (c)		25	50
West Hollywood (w)		25	18
Croissant Park (w)			2
Central Elementary (w)			16
Stranahan (w)			12
Wilton Manor (w)			15

Discussion

There are certainly many more simple indices which are indicative of health progress or lack of progress in fields of concern of the local health department. Most of the figures mentioned are readily obtainable with little use of time and money and may prove to be most informative. Health departments depend on the spread of health information and think that everything is fine in the absence of epidemics and with favorable morbidity and mortality statistics, but may be surprised, particularly in certain areas, with the comparative figures evidenced in this report.

It has been the philosophy of this health unit to have more and more patients under the care of the private physician. With a background of good economic status of the general population, it has been possible to close all venereal disease clinics and work with the physicians relevant to the epidemiology of the cases. The largest infected group (county jail prisoners), however, has been under the jurisdiction of the Health Department.

Likewise, the Tuberculosis Public Clinics were discontinued, and all patients were placed under the care of private physicians. The Health Department believes that the increased cooperation with physicians (80 per cent of all new cases of tuberculosis are discovered by the private physician in Broward County) has resulted in a better case-finding and isolation program.

It is well known that material progress in the reduction of maternal and infant deaths will only come with better hospitals and all deliveries taking place in good hospitals. With this objective in mind, such a program has been instituted, resulting in the building of a new 100 bed hospital.

Immunization is being carried out and the diagnosis of cancer and diabetes is being made in greater volume by the private physician. The Health Department is therefore able to spend more time and money in other fields.

Along with this trend, there is the legal and moral responsibility of the Health Department to compile some "estimate" or statistics such as the suggested indices so that the health status of the patient — the citizenry — will be known at all times.

501 South Andrews Street.

Our Midwife Problem

Clarence L. Brumback, M.D.
West Palm Beach

Reduction of the number of maternal and infant deaths is one of the primary objectives of public health work in Florida. Programs designed to achieve this objective have given a great deal of attention to midwives, who conduct a large percentage of the total deliveries in the state. This paper attempts consideration of a few phases of the midwife problem.

Historical

Primitive women at first bore children alone like animals in the field. Later, some were assisted by old women of the tribe, prototypes of the midwife. Eventually, the midwife became a regular member of ancient society, delivering babies as a profession. Thus in the first chapter of Exodus we read that midwives found favor with God because they did not destroy male infants as Pharaoh had commanded. Under the influence of Hippocrates, midwifery reached relatively high standards. Although most of the deliveries were performed by midwives, their practice was governed by physicians who assisted with difficult cases. This improvement was continued through the time of Soranus of Ephesus, who introduced podalic version in the second century A.D. During the middle ages the teachings of Hippocrates and Soranus were almost forgotten. Obstetrics was beneath the dignity of physicians, and in 1580 a law was necessary in Germany prohibiting shepherds from practicing midwifery. During the sixteenth century Paré did much to increase the respectability of midwifery, and a school for midwives was established in Paris.

The modern era has seen tremendous advances in obstetric knowledge and a corresponding increase in the importance of physicians for maternity services. In Europe, trained midwives continue to attend a large proportion of births. In America, the percentage of midwife deliveries is decreasing while hospital deliveries by physicians are increasing.* It must be said at this point that the trained midwife of European countries cannot be compared with the majority of midwives in this country, who are relatively untrained.

A great deal of effort has been made during recent years toward reducing the number of midwife deliveries and increasing the percentage of deliveries attended by physicians, in hospitals when at all possible. The results obtained have required a tremendous amount of public education because even with physicians and hospital services available, many women turn to the familiar midwife. Economic factors play a part, but there are other important reasons, such as superstition and prejudice. There are areas in this country where physicians are insufficient in number to meet demands for medical services; some large areas have no physicians at all. In such places midwives are necessary if the number of deliveries by others less qualified are to be reduced. Where midwives are needed, health departments and practicing physicians are responsible for giving them the best possible supervision and training.

In Florida, the tendency has been away from large midwife training institutes and schools toward smaller local meetings held periodically as required by county health officers. Midwives are required to do everything possible to have patients consult a private physician or register at approved prenatal clinics. Chapter XIX of the State Sanitary Code prescribes requirements for licensing and lists rules and regulations pertaining to the practice of midwifery. A great many of the older midwives and those in poor health have been given "honorable discharges." Others who were incompetent or guilty of malpractice have had their licenses suspended or revoked. In this way

Director, Palm Beach County Health Department.

Read before the Florida Health Officers' Society, Seventh Annual Meeting, Hollywood, April 27, 1952.

*In 1949, 87 per cent of live births in the Unted States were in hospitals, 8 per cent were attended by physicians outside hospitals, and 5 per cent were delivered by midwives or others. In 1935 only 37 per cent of all births were in hospitals, 50.5 per cent were attended by physicians outside hospitals, and 12.5 per cent were delivered by midwives or others (Dublin).

the total number of midwives practicing in Florida has been greatly reduced, and those remaining are better qualified than were the old "granny women" who used axle grease, soot and cobwebs to dress the umbilical cord.

Present Status of Midwives in Florida

How do the midwives in Florida at the present time compare with those of past years regarding number, age, race, training, and percentage of the total number of babies delivered?

In 1931 Hanson and Blachly made a study of the status of midwifery in Florida. The entire state was not included, but data were obtained from 58 of the 67 counties, comprising 85 per cent of the total population and 83 per cent of the Negro population. Figures obtained, when compared with current information, show some interesting trends.

NUMBER.—The 1931 study included information on 1,147 midwives and 156 other persons, each of whom delivered one or more babies in 1930, or was licensed to do so. Of the midwives, 157 were white persons and 990 Negroes. It is of interest to note that six of them were male. There were 998 licensed by the State Board of Health, and 149 were unlicensed. The license had no legal basis at that time, but was started in 1932 as an educational measure.*

In 1951, there were 423 midwives licensed in Florida. Since any person who practices midwifery without a license from the State Board of Health is subject to prosecution, no unlicensed midwives are listed. That a number of persons other than physicians or midwives still attend births is shown by the fact that they delivered 1 per cent of the babies born in Florida in 1950.

Of the 423 licensed midwives registered with the State Board of Health in 1951, 35 were white persons and 388 Negroes. There were no males included in this group. These midwives were distributed through 65 counties, the largest number for any county being 28 and two counties having none.

AGE.—Data on age were obtained on 1,070 midwives in the 1931 study. When comparisons are made with 1951 figures according to percentages in the various age groups, the following information is obtained:

*This study included only a fraction of the total number of midwives in the state. Miss Ruth E. Mettinger, Director of the Division of Public Health Nursing, State Board of Health, reports that there were over 4,000 midwives in 1934 and an estimated 6,000 to 7,000 in 1922.

Age Groups	*1931* Per Cent	*1951* Per Cent
Under 40	6	9
40 to 50	25.5	18
50 to 60	39	29
60 to 70	22.5	30
Over 70	7	14

In 1931 over 31 per cent of the midwives studied were under 50 years of age as compared with 27 per cent in 1951. Also, in 1931 approximately 29.5 per cent were over 60 years of age, compared with 44 per cent in 1951.

EDUCATION.—In 1931, 28 per cent of 1,059 midwives could not read at all, compared with 5 per cent in 1951. Thirty-four per cent could not write at all in 1931, compared with 6.4 per cent in 1951. With regard to professional training, there are insufficient data available to make accurate comparisons. Fifteen of the midwives licensed in 1951 were registered nurses and eight were certified nurse midwives. The others have received their training in various ways; by working under the supervision of physicians and other midwives, by serving in hospitals, and through midwife training programs conducted by the State Board of Health.

PERCENTAGE OF DELIVERIES.—Comparison of figures on the percentage of deliveries performed by physicians, midwives and others in Florida during the past 20 years shows a fairly consistent and progressive decrease in the percentage of deliveries by midwives and a corresponding increase in the percentage of deliveries by physicians for both white persons and Negroes. The percentage of deliveries by persons other than physicians or midwives has remained fairly constant for both races over most of the last 20 years. These figures are shown in tabular form below:

	Physicians			*Midwives*			*Other*		
	T	W	N	T	W	N	T	W	N
Year	Per Cent			Per Cent			Per Cent		
1950	85	98	52	14	2	47	1	*	1
1949	83	96	48	15	2	49	2	2	3
1948	82	96	47	16	2	51	2	2	2
1947	83	96	45	15	2	53	2	2	2
1946	82	96	43	16	2	55	2	2	2
1945	81	96	40	17	2	58	2	2	2
1944	80	95	37	18	3	61	2	2	2
1943	78	94	33	20	4	65	2	2	2
1942	76	93	31	22	5	67	2	2	2
1941	73	91	29	25	7	70	2	2	1
1940	73	91	28	25	7	70	2	2	2
1939	71	90	28	27	8	70	2	2	2
1938	70	89	25	28	9	73	2	2	2
1937	69	89	23	29	9	75	2	2	2
1936**	69	88	23	29	10	76	2	2	1
1935**	70	89	25	29	9	73	1	2	2
1934**	69	89	25	29	9	73	2	2	2
1933**	66	86	20	33	13	78	1	1	2
1932**	66	86	21	33	13	78	1	1	1
1931**	66	87	19	33	12	80	1	1	1
1930**	67	88	20	32	11	79	1	1	1

* Less than ½ of 1 per cent.
** By place of occurrence.

A Survey of Maternal and Neonatal Deaths

In order to obtain figures which might help to evaluate the effectiveness of midwife training and supervision in Palm Beach County, a survey of maternal and neonatal deaths was made over the five year period 1947-1951. The County Health Department has been in operation only during the last four of those years. All maternal and neonatal deaths were listed as to cause of death, race, and whether physician, midwife, or other person attended the delivery.

Palm Beach County has seven midwives licensed at the present time, one third the number practicing 10 years ago. The reduction has been almost entirely in those over 60 years of age, only three in that age bracket now being in practice compared with 18 in 1942. Midwives are required to attend meetings conducted every second month by the County Health Department. They are instructed not to accept patients who have not received prenatal supervision by a practicing physician or in one of the health department prenatal clinics. These clinics are operated in four different areas of the county, each being served by practicing physicians in those areas. Patients who can afford private care are urged to see their own physician. Midwives are required to be present at prenatal clinics held in their area and are given instruction and information about the patients for whom they are engaged.

Midwives are required to report deliveries within 24 hours. Public health nurses routinely visit the mother and baby within 48 hours. Return visits are made during the second week and when the baby is a month old. Mothers are urged to return to the clinic for postpartum examinations. In 1951 there were 425 mothers admitted to prenatal clinics. Unfortunately, over two thirds of these women were not seen until the third trimester. During the past two years 23 patients have been referred to private physicians for delivery because of abnormalities. Midwives are authorized to attend only cases of normal pregnancy or labor.

Neonatal Deaths and Stillbirths.—During the five year period from 1947 through 1951 midwives delivered approximately 1,890 of the 11,824 babies born in Palm Beach County. This was 16 per cent of the total deliveries and nearly 43 per cent of the Negro deliveries. Of these babies delivered by midwives 46 or about 2.4 per cent died in the first month of life, a neonatal death rate of 24.3 per 1,000 live births. The chief value of these figures is for reference points to establish future trends because the majority of women scheduled for midwife delivery are being referred to physicians if any abnormality is observed during pregnancy or labor. The neonatal death rate for babies delivered by midwives is certainly much lower than the rate of 172.4 per thousand live births for babies delivered by persons other than physicians or midwives. Forty-seven of the babies delivered by midwives were stillborn, a rate of 24.9 per 1,000 live births.

Maternal Mortality.—Only one maternal death could be attributed directly to a midwife delivery during the five year period.

Comparison of Leading Causes of Neonatal Death.—Comparison of the five leading causes of neonatal death for physicians and midwives shows immaturity listed as the leading cause for both white and Negro infants delivered by physicians over the five year period, 1947 through 1951. The leading cause of death for newborn infants delivered by midwives during the same period was tetanus neonatorum, although the rate for this cause has decreased markedly. Comparison of five leading causes of neonatal death among babies delivered by physicians versus those delivered by midwives in Palm Beach County, 1947-1951, is presented as follows:

	Leading Cause of Neonatal Death, Palm Beach County 1947-1951	Live Births Rate per 1,000
Physician Deliveries		
1. Immaturity	156	13.9
2. Congenital malformations	29	2.6
3. Postnatal asphyxia and atelectasis	27	2.4
4. Birth injuries	21	1.9
5. Hemolytic disease of newborn	9	0.8
Midwife Deliveries*		
1. Tetanus	16	8.5
2. Immaturity	10	5.3
3. Cause unknown*	9	4.8
4. Birth injuries	6	3.2
5. Postnatal asphyxia and atelectasis	2	1.1

*Insufficient information on death certificates made impossible the classification of a number of deaths following midwife deliveries. These have been included under the heading of "Cause unknown." Proper classification of such deaths would increase rates for other causes listed.

Approaches to Solution

Attempts at solving the midwife problem have followed two main directions: (1) Improved training and supervision, and (2) decreasing or eliminating the midwives.

In 1948 the Suwannee County Health Department and the State Midwife Teacher, with the cooperation and assistance of the county medical society, county hospital, county schools, local

business firms and civic organizations, conducted an excellent training program for young Negro women to replace old midwives. The trainees assisted in the prenatal and well child clinics operated by the County Health Unit. They observed deliveries and assisted in the maternity ward and nursery at the hospital. Discussions and demonstrations were conducted and practical experience given in maternal and infant care. The trainees made antepartum and postpartum visits to homes. Practicing physicians supervised the required number of deliveries. This is an example of the type of programs being carried on throughout the state to improve midwife training and to replace unqualified with qualified persons.

In 1950 a group of practicing physicians, hospital administrators, and health department workers in the "glades" area of Palm Beach County developed plans for low cost delivery services in two local hospitals. Fees were established for minimum periods of hospitalization, eligibility to be determined by the area welfare worker and public health nurses. Applicants for delivery under this plan are required to attend prenatal clinics conducted by the county health department. An active educational program is carried on by public health nurses to explain the advantages of hospital delivery. Prior to April 1, 1952 a total of 103 patients, 83 Negro and 20 white women, had taken advantage of the service. As a result of the development of this plan it has been possible to reduce the number of midwives in Palm Beach County.

Summary

The number of midwives in Florida has been greatly reduced in the last 20 years through efforts of the State Board of Health, and the enactment of legislation setting up requirements for licensure. In spite of the plan for retiring the older midwives and replacing them with younger, better trained women, there is a higher percentage of licensed midwives over 60 than was shown in a group studied in 1931. This is probably explained by the fact that replacement of all retired midwives has not been necessary. Educational qualifications have improved since 1931.

The percentage of midwife deliveries has markedly decreased during the past 20 years, and the percentage of physician deliveries has increased in like proportion. These trends are observed in both white and Negro races. There has been little change in the proportion of deliveries performed by persons other than physicians and midwives.

Neonatal and stillbirth mortality rates for infants delivered by midwives are lower than might be expected without considering the requirement that patients showing abnormalities be referred to physicians for delivery. The prominence of tetanus as a cause of death among newborn infants delivered by midwives indicates the need for better supervision and training. The effectiveness of such supervision is shown by the decrease of tetanus neonatorum in Palm Beach County during the past five years.

The midwife problem has been approached chiefly in two ways:

1. Improved training and supervision, with the State Board of Health, practicing physicians and local health departments cooperating in supplying clinical and laboratory service to the women who are delivered by midwives.
2. Reducing the number of midwives through control of licensing. Before this reduction can be accomplished, physicians and hospitals must be available in all areas to supply the needed services and the public must be educated to accept such services.

References

Brown, R. C.: The History of Midwifery, Maternity and Child Welfare, vol. 15, nos. 10-11 (Oct.-Nov.) 1931.

Dublin, L. I.: The Facts of Life From Birth to Death, New York, The Macmillan Company, 1951.

Fell, F.: Midwifery Delivery Service: New Era for Mothers and Babies in Santa Fe, New Mexico, Am. J. Nursing 45:220-222 (March) 1945.

Ferguson, E. R.: Nurse-Midwives Serve Rural County, Pub. Health Nursing 35:187-192 (April) 1943.

Graves, J. O.: Midwife Treatments and Remedies, Library, Florida State Board of Health, Jacksonville.

Graves, J. O.: The Midwife Program in Florida, Pub. Health Nursing (Oct.) 1939.

Hall, M. F.: Public Health Statistics, New York, Paul B. Hoeber, Inc., 1949.

Hanlon, J. J.: Principles of Public Health Administration, St. Louis, C. V. Mosby Company, 1950.

Hanson, H., and Blachly, L. S.: Present Status of Midwifery in Florida, South. M. J. 25:1252-1258 (Dec.) 1932.

Haultain, W. F. T.: Now and Then; Statistical Review of Progress of Midwifery During the Last 20 Years with Thoughts for Future, Am. J. Obst. & Gynec. 55:733-757 (May) 1948.

Hemschemeyer, H.: Nurse-Midwife is Here to Stay, Am. J. Nursing 43:913-916 (Oct.) 1943.

Kirkland, E. J.: Report of Visit to Suwannee County, Florida State Board of Health, 1948. (Courtesy Miss Ruth E. Mettinger.)

Marchetti, A. A.: Catharina Geertruida Schraders and Her Diary; Note on History of Obstetrics and Especially on History of Placenta Previa, Am. J. Obst. & Gynec. 50:160-167 (Aug.) 1945.

Matthews, M. W.: Personal communication.

Mettinger, R. E.: Personal communication.

Puxon, M.: Handbook of Midwifery, London, Sylviro Publications, Ltd., 1949.

Robinson, V.: The Story of Medicine, New York, Albert & Charles Boni, 1931.

Rosenau, M. J.: Preventive Medicine and Hygiene, ed. 7, edited by K. F. Maxcy, New York, Appleton-Century-Crofts, Inc., 1951.

Rue, C. B.: Public Health Nurse in the Community, Philadelphia, W. B. Saunders Company, 1945.
Schools of Nurse Midwifery, Pub. Health Nursing 35:477-478 (Aug.) 1943.
Smillie, W. G.: Preventive Medicine and Public Health, New York, The Macmillan Company, 1952.

P. O. Box 29.

Discussion

Dr. Paul W. Hughes, Fort Lauderdale: The improvement in midwife supervision in the local health unit and the correspondingly good results are well depicted in Dr. Brumback's paper. The rapidly changing trend for most deliveries to be made in hospitals is noted. It would appear that the midwife problem is becoming less a problem due to the good work of the midwives and the increased number of hospital deliveries by physicians.

I note that the neonatal death rate for babies delivered by persons other than physicians and midwives is eight times greater than the neonatal death rate of babies delivered by midwives. If 1 or 2 per cent (700-1,500) of the 70,000 births in Florida are delivered by this unknown "other" group, it would seem that such delivery would invite further investigation on the part of the Bureau of Maternal and Child Hygiene.

Mental Deficiency

William L. Musser, M.D.
WINTER PARK

The physician is daily called upon to face various crises. He usually meets these situations with unflinching courage. This paper concerns itself with a crisis which is extremely common, but which has not been given the same degree of attention and rational understanding as have other situations in the practice of medicine. I speak of the increasing problem of mental deficiency.

It is doubtful whether anyone knows the exact incidence of mental deficiency in all its forms. It is also doubted whether the total number of existing cases is known. There have been no recent comprehensive surveys of the problem, and apparently there will be none until an aroused and educated public demands that the problem of mental deficiency be met in a more satisfactory manner.

Educators seem to agree that from 2 to 5 per cent of the general population is mentally deficient. It is said that there are now approximately 1,500,000 mentally retarded children and adults in this country. Of this number there are only 125,000 in institutions. Twelve per cent of our school population "differs" to the extent that it needs some form of special education. As of 1951, the children in this group numbered from 3 to 4 million. Included are not only the mentally retarded but also those children with emotional difficulties and psychotic disorders. An average of 1 out of every 50 births today results in a mentally retarded child. Mongolism alone, which accounts for only 1 per cent of all cases, has an annual incidence which approaches the annual incidence of paralytic poliomyelitis and also of diabetes mellitus.

Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 30, 1952.

Classification

Any attempt to define such a complex sociobiologic problem must necessarily be a lengthy one. Mental deficiency, however, is a term used to describe a group of persons who, because of a retardation in mental development, require special advantages and/or social and economic adjustments in order that they may reach the maximum of adjustability in any environment.

A brief clinical classification is as follows:

I. Prenatal
  A. Hereditary
    1. Familial and subcultural defect
    2. Hereditary idiocy
    2. Phenylpyruvic oligophrenia
    4. Congenital ectodermoses, neurofibromatoses, et cetera
  B. Infection
    1. Congenital syphilis
    2. Toxoplasmic encephalitis
    3. German measles
  C. Irradiation
  D. Isoimmunization
  E. Unknown etiology
    1. Mongolism
    2. Congenital cerebral palsy
    3. Cretinism
    4. Cranial anomalies
    5. Undifferentiated amentia
II. Birth trauma
III. Postnatal
    1. Central nervous system infection
    2. Cerebral trauma
    3. Cerebral vascular disorders

4. Cerebral degenerative disorders
5. Muscular dystrophies
6. Recurrent convulsions

With this outline in mind, one can readily view the vast scope of the problem. I wish, however, to make one point extremely clear. Less than half of all cases of mental deficiency are due to hereditary causes. More than half of these cases are due to causes possibly preventable or are cases whose incidence could continually be reduced.

The modern attitude toward the problem of mental deficiency is improving, but it is yet far from adequate. We are dealing with an area to which there is a stigma attached. Recent advances in medicine indicate that stigmas may be conquered. The progress made recently in the fields of poliomyelitis, cerebral palsy, epilepsy, and multiple sclerosis may be mentioned in this respect. Only one factor conquers stigma. This is public understanding of a problem and definite action toward its solution.

Physicians and the general public have always considered mental deficiency a stationary or permanent defect. This attitude is an easy one to develop, but recent observations indicate that this condition has a progressive character, just as does mental illness. Thus, there should be more interest and attention given to the newborn or early case. This "hopeless" attitude has, more than any other factor, caused the present inadequate institutional systems, lack of teachers in this field, and tales of witchcraft which continue to exist.

Mental deficiency is not simply a matter of low intelligence. It is a sociobiologic problem which forces us to delve into social incompetence, intellectual retardation, and various arrests of growth and development. It should not be confused with mental illness. The mentally retarded cannot and never will be able to compete with society on equal terms. The mentally ill, on the other hand, may or may not be restored to useful, active lives.

The Physician's Role

These facts should be impressed upon physicians, because studies show that the doctor is an important early factor in creating either a hopeful or a hopeless situation. It is indeed with regret that it has been shown in many cases one wrong word or attitude from the doctor may well wreck an entire family emotionally, and deprive a retarded child of the attention and training he needs. Perhaps the ideal approach to the parental aspect of the problem is to indicate the genuine scientific truth about the child as early as possible. If this cannot be done immediately, then it is the duty of the physician actively to assist the parent in arriving at the truth as early as possible. It has been stated repeatedly that mental and emotional illness is our country's leading health problem, affecting an estimated 9,000,000 people, and accounting for more patients in mental hospitals than in all other hospitals combined. Here is an excellent opportunity for the doctor to alleviate the early beginnings of such disturbances as self pity, self condemnation, and utter confusion. Before definite advice is given to the parents concerning the future of their child, one should acquaint himself with current opinions on this subject.

When parents are confronted with the problem of a mentally retarded child and ask their physician the cause, and later concerning placement of the child in an institution, they embark into a sea of ignorance and detachment. There is the usual statement that the cause is unknown, and they are advised to apply to state or private institutions. It is peculiar that seldom is any thought given to advising that the child be kept at home for a while. One cannot say definitely that all mentally retarded children should be institutionalized at birth. Before such a statement can be made, there should be some investigation into the nature and availability of an institution, and also the characteristics of the home. Most state institutions will not accept these infants until they are approximately six years of age. At this time, the parent is confronted with a long waiting list for a vacancy. A vacancy commonly means a death. This deplorable overcrowded and understaffed condition of our institutions is sufficient proof that people and government have not kept up with the problem. In private training schools, also, conditions are often intolerable from the standpoint of management or inadequacy of physical surroundings. The fees associated with private schools ($100 to $300 a month) are within the reach only of the well-to-do or wealthy.

Recent studies clearly indicate the need for an improved public and professional understanding of the problem of mental deficiency. It is a growing problem, and current thought, legislation, and research are not level with it. This country spends five hundred million dollars annually for the maintenance of its mental institutions. It is a glaring deficiency that we spend only three million dollars in research into all mental and nervous

diseases or conditions. Isolated research in mental deficiency is finally under way, but it seems poorly coordinated with research in other fields. The real need seems to be for more general research in the basic problems of human reproduction, and not so much in various isolated areas.

Parent Groups

In the past, the physician has been unaided in his efforts to cope with the problems of the mentally retarded child and his parents. All authorities agree that the brightest sign on the horizon at present is the formation of certain parent groups over the country. Just as the formation of the Parent-Teacher Association a few years ago brought about increased efficiency and satisfaction of needs in our public school system, so will these groups help bring about improvement in the care and training of retarded children. The formation of these groups means that the unjustifiable stigma is no longer so potent, and this old witch is being dragged out of the closet, just as epilepsy was years ago. These parents and friends of retarded children are discussing their problems with each other, and are beginning to demand that their problem be met. It is with much pleasure that I announce that Florida now has one of the first of such groups in this area. The aims and objectives of some of these organizations are as follows:

1. To secure the advancement of retarded children.
2. To promote an improved understanding of retarded children and secure favorable publicity.
3. To promote legislation for the advancement of retarded children.
4. To disseminate information concerning retarded children.
5. To work toward the improvement of local facilities for the care and training of retarded children.

In closing, I should like to outline what I believe the physician can do:

1. Remove his personal indifference to the problem of mental deficiency.
2. Become more aware of the emotional needs of the parents.
3. Assist the local Association for Retarded Children in its efforts.
4. Appeal to legislators for adequate and proper facilities for the care and training of the mentally retarded.

Pearl S. Buck has said, "We must fight for the right of our children to be born sound and whole. What has been need not forever continue to be so. The lives of these little children, thwarted as they are, need not be meaningless."

References

Benda, C. E.: Developmental Disorders of Mentation and Cerebral Palsies, New York, Grune & Stratton, Inc., 1952.
Benda, C. E.: Mongolism and Cretinism, ed. 2, New York, Grune & Stratton, Inc., 1949.
Ingalls, T. M.: Pathogenesis of Mongolism, Am. J. Dis. Child. 73:279-292 (March) 1947.
Ingalls, T. M.: Etiology of Mongolism; Epidemiologic & Teratologic Implications, Am. J. Dis. Child. 74:147-165 (Aug.) 1947.
Nelson, W. E., editor, Textbook of Pediatrics (Mitchell-Nelson). With the Collaboration of Sixty-Three Contributors, ed. 5, Philadelphia, W. B. Saunders Company, 1950.
Numerous personal communications.

Box 1386.

Discussion

Dr. Walter W. Sackett, Jr., Miami: I must admit that until listening to Dr. Musser's ideas on mental deficiency, I have been guilty of being one of those apathetic doctors who, without deviation, recommend institutional care for mentally deficient children. Certainly Dr. Musser offers another approach to a problem that heretofore has been treated with a monotonous sameness for centuries.

If there has been a defect in our educational system, it is that which permits each individual to be educated to a degree far below his potential capacity. It is in mentally defective persons that such a fault is projected in glaring outlines. We must make every effort to develop the capacity of each one of these mental defectives to as near 100 per cent as possible. Only in this way do we stand any chance of salvaging for a useful life a fair percentage of these unfortunate persons. In like fashion only can the remainder be insured a possibility of leading a life of some meaning to themselves. The results of such an educational training program would be subsequently reflected in the lowering of the crime rate in those cases so often associated with some form of violence, and so frequently participated in by those defectives of whom Dr. Musser so hopefully speaks. The cost of such a program would eventually be defrayed in good part by the lessening of such crime with its present high penal expense.

With the crowded conditions prevalent in our mental institutions, here lies a partial solution to that problem. If a saner approach to these mentally defective children could only deflect a portion of the load carried by our state institutions, then a wholehearted effort on our part would be well worth while. Dr. Musser in his clinical classification gives the accoucheur, whether he be the obstetrician or the general practitioner, reason to stop and think. He mentions, in passing, birth trauma, and anyone engaged in the delivery of babies might well analyze his delivery technic with the idea in mind of lessening the possibility of its occurrence.

Dr. Murphey, in his opening address to the House of Delegates yesterday, issued a warning as to the dangers of permitting large lay groups to practice medicine as they have already been doing. Surely this is a time, and not ten years hence, for us to step into this field of medicine and do our part.

Truly this is an age of health reforms, even as the nineteenth century has been described as an age of social reforms. It would seem that the first part of our century of health reform has been dedicated to the physically handicapped, as manifested by the great strides and improvements in medicine and surgery as well as improved attitudes toward such conditions as heart disease, poliomyelitis, cerebral palsy and muscular dystrophies. The latter part of this same century would seem to be concerned with mental health reforms, as manifested by the formation of mental health societies and by this new attitude on mental deficiency. Certainly Dr. Musser's paper points us the way to a new road, all in keeping with this age of mental health reform. We as physicians would all do well to point our sights along this road.

DR. SAMUEL G. HIBBS, Tampa: The question of the treatment of mental deficiency is one which I have been interested in ever since I have been in psychiatry. Dr. Musser's paper brought out the fact that this is not a typical mental illness, but an intellectual defect which in many cases can be helped with adequate and understanding training much more than heretofore we have ever thought possible.

There are a great many of these patients who need nothing more than adequate education. I had in my office just two weeks ago a 29 year old man, yet intellectually he was a child. His mother had overprotected him. He was mentally defective, but actually he was rather clever in so far as his efficiency was concerned. He could have been a fairly adequately adjusted person today if his parents had permitted him some social education. He was kept at home. His mother was a school teacher. She taught him reading, writing and arithmetic, but she also is still tying his shoe strings. She is still helping him dress. She is still helping him bathe, a man 29 years of age. There are many people of this type who could be helped if relatives and friends of those so afflicted were sufficiently informed and adequate training programs were instituted.

I think that we should know that our particular Farm Colony in Florida is not only for the mentally retarded, but also for those afflicted with epilepsy. To me this has always been a strange combination. Many epileptics are not mentally retarded, and most mentally retarded are not epileptics. Yet a combination like this in a group not only confuses those who are there as patients but also confuses those who are trying to help them. We had this problem in the state from which I originally came, and it took us a great many years to get the groups separated. After it was accomplished, the epileptics did much better in their particular institution, and the mental defectives caused much less difficulty and were far more effective in their particular way of handling themselves than they had even been when grouped with the epileptics.

In closing I should like to inform you that a bill was passed in the last legislature adding narcotic addicts to the patients of the already crowded Farm Colony at Gainesville. It is a most absurd law; but in the Florida statutes of 1951 you will find this bill which says that narcotic addicts will be arrested, go before a judge and be sentenced for an indeterminate period to the Florida Farm Colony for the feeble-minded and epileptic.

I enjoyed Dr. Musser's paper, and I think he has presented a subject to which we should give more thought.

ABSTRACTS OF MEDICAL ARTICLES

Cerebral Blood Flow and Metabolism in Pernicious Anemia. By Peritz Scheinberg, M.D. Blood 6:213-227 (March) 1951.

Cerebral blood flow and metabolism were measured by the nitrous oxide method in 27 observations on 16 patients with pernicious anemia in an effort to measure the effects of this deficiency state and its treatment on cerebral metabolism and to gather data which might shed some light on the relative importance of the anemia and the specific deficiency in the pathogenesis of the cerebral metabolic defects. The results indicate that a disturbance in cerebral metabolism in pernicious anemia is common, that the mental symptoms observed in these patients are related to the decrease in cerebral metabolism, and that this disturbance is the result of the deficiency state and is not produced by the anemia.

In patients with severe anemia, cerebral blood flow was increased and cerebral vascular resistance decreased; in an equal number with moderate or no anemia, the reverse was true. In both groups, cerebral oxygen and glucose consumption was decreased, as was cerebral venous oxygen tension. There was good correlation between the mental status defects and cerebral oxygen consumption and between severity of neurologiv involvement and cerebral oxygen consumption. There was no correlation between cerebrovascular resistance and cerebral oxygen consumption, nor between degree of anemia and cerebral oxygen consumption.

Specific therapy resulted in a moderate increase in cerebral oxygen consumption and cerebrovascular resistance. In no instance, however, did cerebral oxygen consumption become normal.

The author discusses the disparity between the functional ability of the patients and the low values for cerebral metabolism. It is his conclusion that pernicious anemia results in specific nervous system involvement not related to the anemia and that this damage is at least partially irreversible in many patients.

Renal Lithiasis: Its Treatment and Prevention by Increasing the Protective Urinary Colloids with Hyaluronidase. By Arthur J. Butt, M.D., Ernst A. Hauser, Ph.D., and Joseph Seifter, M.D. J. M. A. Georgia 41:185-190 (May) 1952.

Noting that urine is a highly saturated solution because of the presence of certain colloids, the authors point out that the protective action of urinary colloids is of major importance in preventing precipitation, agglomeration and conglomeration of crystalloids from a supersaturated solution. If the concentration of such protective colloids is insufficient, stone formation begins or is accelerated. In a series of 680 subjects, the

incidence of stone was almost inversely proportional to the degree of protective urinary colloids present. The specimens of urine were subjected to ultramicroscopic examination, determination of electric charge carried by the colloidal particles, determination of the surface tension, and photoultramicrographic studies.

These investigators established that subcutaneous injection of hyaluronidase, mixed with physiologic saline, greatly increases the protective urinary colloids. The colloids are caused to set up a gel, thereby preventing electrolytes present from crystallizing. They act as excellent dispersing agents and prevent the formation of stone.

In 18 of 20 patients studied in one series, all of whom had previously been rapid stone formers, hyaluronidase therapy, 150 turbidity reducing units every 24 to 72 hours, effectively prevented calculous formation or reformation during a period of 11 to 14 months. In a second series of 10 patients with rapidly forming stones, larger doses of hyaluronidase, averaging 300 turbidity reducing units every 24 to 48 hours, resulted in no new stone formation or growth of existing stones over a period of six to 10 months, as evidenced by roentgen examination at 30 to 60 days intervals.

Speech Rehabilitation After Total Removal of Larynx. By Nathaniel M. Levin, M.D. J. A. M. A. 149:1281-1286 (Aug. 2) 1952.

To present a total picture of the patient who has undergone radical laryngectomy and his problems is one aim of this paper. A further purpose is to show that practically all patients, after a total laryngectomy, can acquire a natural form of speech without the use of any artificial aid and that they can resume their former occupations and activities requiring the use of the voice. The more important characteristics of the altered anatomy and physiology following this radical procedure are reviewed. Paramount is total loss of speech, but other pronounced changes also require consideration. In addition, emotional and psychologic disturbances following the operation are considered.

Since the hypopharynx and the upper esophageal sphincter are foremost in importance among the anatomic structures on which esophageal speech depends, laryngeal surgeons make every effort to conserve these and other normal structures that is consistent with the removal of all the malignant lesion. The author describes the mechanism of esophageal speech and emphasizes more consideration in his operative efforts for those structures which anatomically and physiologically take over the functions of the resected larynx and thus may favorably affect future esophageal speech requirements. He presents a resume of successful methods of instruction used in esophageal speech training and also discusses the artificial larynx and other mechanical devices.

Noting that patients with cancer of the larynx who undergo total laryngectomy number in the thousands, Dr. Levin outlines a rehabilitation program essential for them. Their number increases yearly because surgical technics now assure from 50 to 60 per cent of five year cures (and longer), and many of these patients attain their normal life expectancy. By contrast, deep roentgen therapy, without loss of speech of course, promises five year cures in only 10 per cent of patients. Moreover, the mortality and morbidity rates incidental to laryngectomy have been reduced to minimal figures. With the help of antibiotics, sulfonamides, whole blood transfusions, good anesthesia and nutritional intravenous therapy, the period of hospitalization also has been reduced from one of eight to 12 weeks to one of 10 to 18 days.

Now that patients can be reasonably assured of a practical speech development after total laryngectomy, it is recommended as the procedure of choice in selected cases of carcinoma of the larynx. Dr. Levin considers mechanical aids, with all of their deficiencies and disadvantages, unsatisfactory and would reserve them for those few patients who cannot learn a more natural form of speech because of special difficulties. He has found age no barrier to mastery of esophageal speech; his oldest patient was well past 70 and the youngest 27 years of age.

In offering assurance that esophageal speech adequately compensates for vocal loss, he states: "The patient who has mastered esophageal speech is able to talk distinctly in a normal way. The voice is satisfactory for normal speech activities and does not attract unusual attention, though it is somewhat harsh at first. A few patients develop voices so nearly normal that they are not recognized as laryngeal amputees, and their speech improves steadily over a number of years if correct methods are used."

Disturbances of Cardiac Rhythm and Conduction in Congenital Cardiac Disease: Report of 5 Cases. By H. Milton Rogers, M.D., F.A.C.P. Ann. Int. Med. 35:1276-1290 (Dec.) 1951.

A series of 5 cases is presented and discussed in which cardiac arrhythmia or conduction defects were present. In 3 cases of ectopic rhythms, 2 of supraventricular tachycardia and 1 of complete heart block, the cardiac disturbance of rhythm or conduction proved to be acquired in the presence of the following respective congenital cardiac anomalies: probable Eisenmenger's complex, ventricular septal defect and infantile coarctation of the aorta. In 2 cases with arrhythmias, 1 of nodal tachycardia and 1 of paroxysmal tachycardia with Wolff-Parkinson-White syndrome, there was probable congenital origin.

The author is of the opinion that routine electrocardiographic studies in infants and in congenital cardiac disease would probably reveal more frequent evidence of disturbances of cardiac rhythm and conduction associated with congenital cardiac anomalies.

Proctologic Manifestations of Carcinoma of the Prostate. By Raymond J. Jackman, M.D., and James R. Anderson, M.D. Am. J. Surg. 83:491-495 (April) 1952.

The authors present a study of a series of 27 cases from the files of the Mayo Clinic in which carcinoma of the prostate had invaded the wall of the rectum obstructing its lumen or had produced an extrarectal mass. They use these cases of unusual interest to illustrate the different modes of spread of this disease when it involves the rectum and to demonstrate that considerable confusion can, and does, arise with respect to the diagnosis. For their purpose they classify the cases as Group 1, carcinoma of the prostate which produces an extrarectal mass that bulges into the lumen of the rectum and prevents passage of the sigmoidoscope to its usual distance; Group 2, carcinoma of the prostate that encircles the rectum and results in an annual, hourglass type of stricture; and Group 3, carcinoma of the prostate that invades the rectal mucosa with or without either of the first two manifestations.

They point out that the most unfortunate error which can easily occur is to make a diagnosis of primary carcinoma of the rectum in those cases in which invasion of the mucosa has occurred secondarily from the prostatic lesion. In some of these cases only minimal symptoms referable to the urinary tract are present; and unless this possibility is kept in mind, an extensive but futile operative procedure may be undertaken. In view of their findings, they recommend that cystoscopy be performed in men with carcinoma of the rectum who have any urinary symptoms before radical operations for rectal lesions are performed. It is particularly important that this be done if the prostate gland cannot be identified digitally as being separate from the rectal carcinoma. They also recommend that a specimen of tissue from a rectal carcinoma be examined microscopically before resection of the rectum is performed. Routine performance of these two procedures will prevent an extensive rectal operation for a secondary lesion arising from the prostate.

Postoperative Treatment Following Prostatic Surgery. By James B. Glanton, Louis M. Orr and Joseph C. Hayward. J. Urol. 67:533-536 (April) 1952.

This presentation is concerned chiefly with morbidity as related to endoscopic prostatic resection, since in 1,000 consecutive cases of obstructive prostatism it was the operation of choice in 94.33 per cent. The four principal postoperative complications, both immediate and remote, are hemorrhage, incontinence, continuing pyuria and urethral stricture, any or all of which may follow or be associated with prostatic surgery. These are discussed and their causes described.

Hemorrhage occurred in 5.32 per cent of the authors' series. Incontinence occurred in 8.29 per cent of 500 consecutive cases, 7.02 per cent being temporary and 1.27 per cent permanent. Prevention lies in not cutting, unduly traumatizing or fulgurating the external sphincter muscle. It was found that an average period of 12.9 weeks elapses before the urine may be expected to clear after endoscopic resection. Urethral stricture occurred in 16.17 per cent of 500 consecutive cases despite every precaution.

In approximately 75 to 80 per cent of the cases of endoscopic prostatic resection an elevation of temperature to 100 degrees or more developed. After careful evaluation, the routine use of prophylactic antibiotic therapy was discontinued, except when valvular heart disease was present.

It is concluded that the end result following prostatic surgery is in direct proportion to the effectiveness and completeness of postoperative management. The patient receives a list of in-

structions aimed at preventing bleeding. Careful calibration at intervals is carried out. Gentle handling is stressed. Resectoscopes of the proper size are important in avoiding stricture, one of the most frequent and discouraging complications. Strict adherence to asepsis with closed drainage systems during and following the surgical procedure is practiced.

It is the experience of the authors that endoscopic resection affords the patient who is suffering from obstructive prostatism a mortality of 1.30 per cent with an end result as satisfactory as with open prostatectomy.

Interesting Bone Changes in Plain Urograms. By W. L. Fitzgerald and M. D. Thomas, Jr. J. Urol. 67:547-556 (April) 1952.

The authors have condensed and tabulated the pertinent data on bone changes most frequently encountered by the urologist in his daily study of the plain urogram. Their purpose is (1) to present some of the elementary but more important fundamental considerations prerequisite to proper identification of bone lesions, such as those pertaining to bone metabolism, calcium, phosphorus and phosphatase, (2) to describe the classic features of some bone lesions in which the urologist is most interested, notably those characterizing senile osteoporosis, hyperparathyroidism, Paget's disease of bone (osteitis deformans), multiple myeloma, and metastatic lesions arising from carcinoma of the prostate, thyroid, breast, kidney and lung; and (3) to discuss suggested additional clinical, laboratory and roentgen data which are of value in proving or disproving a diagnosis of a presenting bone lesion. Excellent illustrative roentgenograms accompany the article.

New Regimen in Feeding the Critically Ill, Preliminary Report. By John Elliott, Sc.D, Donald W. Smith, M.D., James J. Griffitts, M.D., George T. Lewis, Ph.D., and Patrick V. Ferro, B.S. A. M. A. Arch. Surg. 64:278-285 (March) 1952.

A four year study of the nutritional management of over 500 critically ill patients has been the subject of investigation at the Medical Research Foundation of Dade County. In this article are reported details of the successful solution of certain problems confronting patients who cannot or will not eat.

A new regimen has been developed, based on the newer knowledge of the utilization of amino acids for protein metabolism. It consists of balanced, stable, nutrient solutions fed at a continuous and constant rate through a small, well tolerated tube inserted into the gastrointestinal tract. The content and a brief description of the preparation of the solutions are presented. Data assembled from 254 patients fed by this regimen are also presented, with illustrative case reports.

The regimen described has restored and maintained the desired nutritional status in critically ill patients more effectively than other methods of feeding. It is simple to administer to patients in whom the gastrointestinal tract is available for feeding, and it is extremely well tolerated. Continuous drip feeding of partially hydrolyzed protein appeared to meet the demands of continuous protein metabolism. The nutrient solutions, prepared in sterile and stable form, can be stored at ordinary temperatures for long periods without deterioration. This method of nutritional management has unusually broad applications, especially when prolonged feeding is required for institutional and home care of the critically ill.

Surgical Management of a Patient with Incontinence of the Anal Sphincter Following Ureterosigmoidostomy. By Truett H. Frazier and Alfred Hurwitz. J. Urol. 67:179-183 (Feb.) 1952.

A case is reported which serves to illustrate an unusual complication following bilateral ureterosigmoidostomy and total cystectomy and prostatectomy for carcinoma of the bladder. Complete urinary and fecal incontinence from the rectum persisted and, despite vigorous nursing care, contributed to a progressive excoriation and inflammation of the perineum and buttocks. After five months of complete invalidism and a progressively downhill course, the patient was subjected to operation which, in essence, was substitution of an abdominal ureterosigmoidostomy for a perineal one.

The authors describe a new ileostomy cup with a disposable collecting bag devised by one of them (A. H.), which is held in place by a new double-backed, nonirritating adhesive disk. It was successfully employed to replace the Rutzen bag in this case. Within four months the patient was completely rehabilitated and more than a year postoperatively was asymptomatic and able to manage his cutaneous ureterocolostomy with facility. There was no roentgen evidence of metastases.

FLORIDA MEDICAL ASSOCIATION

OFFICERS AND COMMITTEES

OFFICERS

ROBERT B. MCIVER, M.D., President.....*Jacksonville*
FREDERICK K. HERPEL, M.D., Pres.-elect..*West Palm Beach*
FRANCIS H. LANGLEY, M.D., 1st Vice Pres...*St. Petersburg*
ERASMUS B. HARDEE, M.D., 2nd Vice Pres.....*Vero Beach*
H. QUILLIAN JONES, M.D., 3rd Vice Pres.....*Fort Myers*
SAMUEL M. DAY, M.D., Sec'y-Treas.....*Jacksonville*
SHALER RICHARDSON, M.D., Editor.....*Jacksonville*

MANAGING DIRECTOR

STEWART G. THOMPSON, D.P.H.....*Jacksonville*
ERNEST R. GIBSON, Assistant.....*Jacksonville*

BOARD OF GOVERNORS*

ROBERT B. MCIVER, M.D., Chm...(Ex Officio).*Jacksonville*
JAMES L. BORLAND, M.D...AL-53.....*Jacksonville*
DUNCAN T. MCEWAN, M.D...B-53.....*Orlando*
JAMES H. POUND, M.D...A-54.....*Tallahassee*
NORVAL M. MARR, M.D...C-55.....*St. Petersburg*
JOHN D. MILTON, M.D...D-56.....*Miami*
HERBERT E. WHITE, M.D...PP-53.....*St. Augustine*
DAVID R. MURPHEY, JR., M.D...PP-54.....*Tampa*
FREDERICK K. HERPEL, M.D. (Ex Officio).*W. Palm Beach*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*
HERBERT L. BRYANS, M.D...S.B.H.-53.....*Pensacola*
STEWART G. THOMPSON, D.P.H. (Advisory)...*Jacksonville*

*SUB-COMMITTEES

1. Veterans Care
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
GEORGE M. STUBBS, M.D.....*Jacksonville*
DOUGLAS D. MARTIN, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

2. Advisory to National Foundation Infantile Paralysis
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
H. PHILLIP HAMPTON, M.D.....*Tampa*
ROBERT P. KEISER, M.D.....*Coral Gables*
RICHARD G. SKINNER, JR., M.D.....*Jacksonville*

3. Review of Fee Schedules
JOHN D. MILTON, M.D., Chm.....*Miami*
WOODROW B. ESTES, M.D.,.....*St. Petersburg*
FREDERICK H. BOWEN, M.D.....*Jacksonville*
ODIS G. KENDRICK, JR., M.D.....*Tallahassee*
JAMES B. GLANTON, M.D.....*Orlando*
FLOYD K. HURT, M.D.....*Jacksonville*
HERSCHEL G. COLE, M.D.....*Tampa*
A. FRANKLIN HARRISON, M.D.....*Madison*
JACK O. W. RASH, M.D.....*Miami*
KENNETH S. WHITMER, M.D.....*Miami*
ADELBERT F. SCHIRMER, M.D.....*Orlando*

4. Blue Shield
LEIGH F. ROBINSON, M.D., Chm.....*Fort Lauderdale*

SCIENTIFIC WORK

JAMES N. PATTERSON, M.D., Chm...AL-53.....*Tampa*
CAROL C. WEBB, M.D...A-53.....*Pensacola*
FREDERICK K. HERPEL, M.D...D-54.....*West Palm Beach*
JERE W. ANNIS, M.D...C-55.....*Lakeland*
RICHARD C. CUMMING, M.D...B-56.....*Ocala*

LEGISLATION AND PUBLIC POLICY

H. PHILLIP HAMPTON, M.D., Chm...B-53.....*Tampa*
WILLIAM M. ROWLETT, M.D...AL-53.....*Tampa*
DANIEL A. MCKINNON, M.D...A-53.....*Marianna*
ANGUS D. GRACE, M.D...C-55.....*Fort Myers*
DONALD W. SMITH, M.D...D-56.....*Miami*
ROBERT B. MCIVER, M.D. (Ex Officio).....*Jacksonville*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*

MEDICAL EDUCATION AND HOSPITALS*

JACK Q. CLEVELAND, M.D., Chm...AL-53.....*Coral Gables*
JULIUS C. DAVIS, M.D...A-53.....*Quincy*
ELBERT MCLAURY, M.D...D-54.....*Hollywood*
S. CARNES HARVARD, M.D...C-55.....*Brooksville*
BENJAMIN F. DICKENS, M.D...B-56.....*Fernandina*

*SPECIAL ASSIGNMENT
1. Urge Gifts to American Medical Education Foundation

PUBLIC RELATIONS*

EUGENE B. MAXWELL, M.D., Chm...AL-53.....*Tampa*
LEIGH F. ROBINSON, M.D...D-53.....*Fort Lauderdale*
HOWARD V. WEEMS, SR., M.D...C-54.....*Sebring*
EUGENE G. PEEK, JR., M.D...B-55.....*Ocala*
HENRY L. SMITH, JR., M.D...A-56.....*Tallahassee*

*SPECIAL ASSIGNMENTS
1. Rural Educational Program
2. State Education Campaign

NECROLOGY

ALVIN L. STEBBINS, M.D., Chm...A-56.....*Pensacola*
HUGH WEST, M.D...AL-53.....*DeLand*
JOSEPH HALTON, M.D...C-53.....*Sarasota*
WALLACE H. MITCHELL, M.D...D-54.....*Key West*
JOSEPH J. LOWENTHAL, M.D...B-55.....*Jacksonville*

MEDICAL POSTGRADUATE COURSE

TURNER Z. CASON, M.D., Chm...B-55.....*Jacksonville*
ARTHUR J. BUTT, M.D...AL-53.....*Pensacola*
FRANZ H. STEWART, M.D...D-53.....*Miami*
J. BROWN FARRIOR, M.D...C-54.....*Tampa*
FRANCIS T. HOLLAND, M.D...A-56.....*Tallahassee*

CANCER CONTROL

FRAZIER J. PAYTON, M.D., Chm...D-54.....*Miami*
MILTON C. MALONEY, M.D...AL-53.....*Jacksonville*
ROBERT L. TOLLE, M.D...B-53.....*Orlando*
GEORGE W. MORSE, M.D...A-55.....*Pensacola*
WESLEY W. WILSON, M.D...C-56.....*Tampa*

MEDICAL ECONOMICS

REUBEN B. CHRISMAN, JR., M.D., Chm...AL-53....*Miami*
JOHN E. MAINES, JR., M.D...B-53.....*Gainesville*
HARRISON A. WALKER, M.D...D-54.....*Miami*
WILLIAM H. WALTERS, JR., M.D...C-55.....*Lacoochee*
WILLIAM C. ROBERTS, M.D...A-56.....*Panama City*

VENEREAL DISEASE CONTROL

MELVIN M. SIMMONS, M.D., Chm...C-55.....*Sarasota*
JOHN R. BROWNING, M.D...AL-53.....*Jacksonville*
JOHN C. MCSWEEN, JR., M.D...A-53.....*Pensacola*
WILEY M. SAMS, M.D...D-54.....*Miami*
DAVID W. GODDARD, M.D...B-56.....*Daytona Beach*

TUBERCULOSIS AND PUBLIC HEALTH*

RALPH S. SAPPENFIELD, M.D., Chm...AL-53.....*Miami*
PHILLIP W. HORN, M.D...B-53.....*Jacksonville*
ERASMUS B. HARDEE, M.D...D-54.....*Vero Beach*
LOUIS J. GARCIA, M.D...C-55.....*Tampa*
HARRY S. HOWELL, M.D...A-56.....*Lake City*

*SPECIAL ASSIGNMENT
1. Diabetes Control

STATE CONTROLLED MEDICAL INSTITUTIONS

William D. Rogers, M.D., Chm...A-56....*Chattahoochee*
James L. Anderson, M.D...AL-53.....*Miami*
Bailey B. Sory, Jr., M.D...D-53.....*Palm Beach*
James G. Lyerly, M.D...B-54.....*Jacksonville*
Samuel G. Hibbs, M.D...C-55.....*Tampa*

MATERNAL WELFARE

E. Frank McCall, M.D., Chm...B-56.....*Jacksonville*
T. Bert Fletcher, Jr., M.D...AL-53.....*Tallahassee*
Lowrie W. Blake, M.D...C-53.....*Bradenton*
John N. Sims, Sr., M.D...A-54.....*Live Oak*
Ralph W. Jack, M.D...D-55.....*Miami*

CHILD HEALTH

Luther W. Holloway, M.D., Chm...B-53....*Jacksonville*
James R. Boulware, Jr., M.D...AL-53.....*Lakeland*
Warren W. Quillian, M.D...D-54.....*Coral Gables*
Daniel F. H. Murphey, M.D...C-55.....*St. Petersburg*
Courtland D. Whitaker, M.D...A-56.....*Marianna*

CONSERVATION OF VISION

Ralph N. Greene, Jr., M.D., Chm...AL-53..*Jacksonville*
William Y. Sayad, M.D...D-53.....*West Palm Beach*
Sherman B. Forbes, M.D...C-54.....*Tampa*
G. Tayloe Gwathmey, M.D...B-55.....*Orlando*
Mozart A. Lischkoff, M.D...A-56.....*Pensacola*

ADVISORY TO WOMAN'S AUXILIARY

C. Robert DeArmas, M.D., Chm...B-55....*Daytona Beach*
Benjamin H. Sullivan, M.D...AL-53.....*St. Petersburg*
Edward F. Shaver, M.D...C-53.....*Tampa*
James L. Anderson, M.D...D-54.....*Miami*
Taylor W. Griffin, M.D...A-56.....*Quincy*

REPRESENTATIVES TO INDUSTRIAL COUNCIL*

Charles R. Burbacher, M.D., Chm...D-55..*Carat Gables*
Fred H. Albee, Jr., M.D...AL-53.....*Orlando*
G. Frederick Oetjen, M.D...B-53.....*Jacksonville*
Chas. L. Farrington, M.D...C-54.....*St. Petersburg*
Lee Sharp, M.D...A-56.....*Pensacala*

*SPECIAL ASSIGNMENT

1. *Industrial Health*

COUNCILOR DISTRICTS AND COUNCIL

Eugene G. Peek, Jr., M.D., Chm...AL-53.....*Ocala*
First—Francis M. Watson, M.D...1-54.....*Marianna*
Second—Benjamin A. Wilkinson, M.D...2-53..*Tallahassee*
Third—William C. Thomas, Jr., M.D...3-54..*Gainesville*
Fourth—Eugene L. Jewett, M.D...4-53.....*Orlando*
Fifth—Hugh G. Reaves, M.D...5-53.....*Sarasota*
Sixth—Emmett E. Martin, M.D...6-54.....*Haines City*
Seventh—Erasmus B. Hardee, M.D...7-54....*Vero Beach*
Eighth—Donald W. Smith, M.D...8-53.....*Miami*

GRIEVANCE COMMITTEE

Walter C. Payne, M.D., Chm.....*Pensacala*
David R. Murphey, Jr., M.D.....*Tampa*
Herbert E. White, M.D.....*St. Augustine*
Joseph S. Stewart, M.D.....*Miami*
William C. Thomas, Sr., M.D.....*Gainesville*

ADVISORY TO SELECTIVE SERVICE FOR PHYSICIANS AND ALLIED SPECIALISTS

J. Rocher Chappell, M.D., Chm.....*Orlando*
Thomas H. Bates, M.D..."A".....*Lake City*
Frank L. Fort, M.D..."B".....*Jacksanville*
Alvin L. Mills, M.D..."C".....*St. Petersburg*
John D. Milton, M.D..."D".....*Miami*

EMERGENCY MEDICAL SERVICE

James V. Freeman, M.D., Chm.....*Jacksanville*
Merritt R. Clements, M.D..."A".....*Tallahassee*
Vernon A. Lockwood, M.D..."B".....*St. Augustine*
Herschel G. Cole, M.D..."C".....*Tampa*
Frederick K. Herpel, M.D..."D".....*West Palm Beach*

A.M.A. HOUSE OF DELEGATES

Louis M. Orr, II, M.D., Delegate.....*Orlando*
Joshua C. Dickinson, M.D., Alternate.....*Tampa*
(Terms expire Dec. 31, 1953)

Reuben B. Chrisman, Jr., M.D., Delegate.....*Miami*
Frank D. Gray, M.D., Alternate.....*Orlando*
(Terms expire Dec. 31, 1954)

Herbert L. Bryans, M.D., Delegate.....*Pensacola*
Thomas H. Bates, M. D., Alternate.....*Lake City*
(Terms expire Dec. 31, 1954)

BOARD OF PAST PRESIDENTS

William E. Ross, M.D., 1919.....*Jacksanville*
H. Marshall Taylor, M.D., 1923.....*Jacksanville*
John C. Vinson, M.D., 1924.....*Fart Myers*
John S. McEwan, M.D., 1925.....*Orlanda*
H. Mason Smith, M.D., 1926.....*Tampa*
John A. Simmons, M.D., 1927.....*Arcadia*
Frederick J. Waas, M.D., 1928.....*Jacksanville*
Julius C. Davis, M.D., 1930.....*Quincy*
William M. Rowlett, M.D., Chm., 1933.....*Tampa*
Homer L. Pearson, Jr., M.D., 1934.....*Miami*
Herbert L. Bryans, M.D., 1935.....*Pensacola*
Orion O. Feaster, M.D., 1936.....*Rentan, Wash.*
Edward Jelks, M.D., 1937.....*Jacksonville*
Leigh F. Robinson, M.D., 1939.....*Fart Landerdale*
Walter C. Jones, M.D., 1941.....*Miami*
Eugene G. Peek, Sr., M.D., 1943.....*Ocala*
John R. Boling, M.D., 1944, 1945.....*Tampa*
Shaler Richardson, M.D., 1946.....*Jacksanville*
William C. Thomas, Sr., M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne, M.D., 1949.....*Pensacala*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey, Jr., M.D., Sec'y., 1951.....*Tampa*

From Our President

Women Physicians — A Salute

The Florida Medical Association has half a hundred women members. Well distributed over the state, they are affiliated with fifteen county medical societies. They engage in various specialties and make their influence felt for the good of their respective communities and their profession.

There is in the Miami area the only Florida Branch of the American Medical Women's Association, composed largely of members of the Dade and Broward county medical societies. A distinguished member is Dr. Jean Jones Perdue of Miami Beach, Regional Director for the South Atlantic division of the national organization. During 1952, Dr. Perdue was chairman of the Women Physicians of the Southern Medical Association and was also chief hostess when that group held its thirty-eighth annual meeting in Miami last November. Serving as hostesses with Dr. Perdue were Dr. Ruth W. Rumsey of Miami, chairman of the Branch, Dr. Rose London of Miami Beach, chairman for the annual dinner, and the other women physicians of the area.

At the dinner, Florida medical history of particular interest came to light. Two oil paintings were presented as souvenirs by Dr. Anna A. Darrow, pioneer artist-physician, who was licensed to practice medicine in Florida in 1909. An orchid in oils went to the physician present who had been licensed the longest and was still in active practice. The recipient, Dr. Elsie Marie Gilbert of Tampa, who received her medical degree in 1900 and her Florida license in 1908, began her Florida medical career in Okeechobee. To another Florida physician, Dr. Frances C. Wilson, also of Tampa, whose license issued in 1948 was the most recent, Dr. Darrow presented a painting of the hibiscus, Florida's state flower.

Since a medical diploma was given a woman for the first time in America in 1849, women have fought valiantly to win an honored place in medicine. Today, they practice by the thousands, and some 150 women are fellows of the American College of Surgeons. Although they represent only about 5 per cent of practicing physicians, this small but important minority deserves high praise for its strength of purpose, tenacity and determination to succeed in a rigorous profession as well as for its notable achievements. Let us salute the dedicated women doctors of Florida and the nation, who elect to take the Oath of Hippocrates that they may become the servants of suffering humanity.

The Journal of the
Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION

P. O. BOX 1018 JACKSONVILLE, FLORIDA

Editor
Shaler Richardson, M.D.

Assistant Editors
Webster Merritt, M.D.
Franz H. Stewart, M.D.

Associate Editors

Louis M. Orr, II, M.D.....Orlando
Joseph J. Lowenthal, M.D.....Jacksonville
Jere W. Annis, M.D.....Lakeland
Herschel G. Cole, M.D.....Tampa
Wilson T. Sowder, M.D.....Jacksonville
Carlos P. Lamar, M.D.....Miami
Walter C. Payne, M.D.....Pensacola

Managing Editor
Stewart G. Thompson, D.P.H.
Ernest R. Gibson, Asst.

Committee on Publication

Shaler Richardson, M.D., Chairman.....Jacksonville
Chas. J. Collins, M.D.....Orlando
James N. Patterson, M.D.....Tampa

Abstract Department

Kenneth A. Morris, M.D., Chairman.....Jacksonville
Walter C. Jones, M.D.....Miami

Keeping Eternally Vigilant

Addressing the Southern Medical Association at its recent meeting in Miami, President Louis H. Bauer of the American Medical Association spoke feelingly of the inferior medical care, resulting from government interference, which he has observed on his trips to Europe as secretary-general of the World Medical Association. He was convinced more than ever that government has no business in the field of medical care or in coming between physician and patient. "Wherever it has been tried, it has been a miserable failure," he said. "Nowhere in the world has government-sponsored or controlled medical care improved the level of medical care, and in most cases it has caused it to deteriorate."

"I have just returned from a trip around the world," he related. "Prior to this, I had made 10 trips to Europe in five years. I have seen with my own eyes conditions in many countries. The medical profession in many countries is struggling to keep its head above water and is beset by increasing government controls and restrictions.

"I have seen clinics and outpatient departments where each doctor has to care for 50 to 60 persons in one to two hours. I have seen doctors unable to prescribe what they thought best for the patient because it was forbidden by the authorities. I have seen doctors employed by the government or insurance bodies who received so little income that the cost of that type of practice was more than they got out of it.

"I have seen hospitals built to accommodate 750 persons with over 1,200 patients. This latter, to be fair, cannot be laid at the door of governments, but to the fact that facilities cannot, for financial reasons, be built adequate to house the patients. Despite all these handicaps I am proud of the medical profession which everywhere is striving to do a good job. It all impressed me, however, over and over, how fortunate you and I are that we live in the United States."

Upon returning from abroad, where he talked with physicians from many countries, A.M.A. Secretary, Dr. George F. Lull, in November expressed similar observations. "The stories some of them told me made my heart ache," he said. "As I left for home, I couldn't help feeling proud of our American system of medical care. In many of the countries I visited, the long arm of socialism has reached into the profession to such an extent that the only thing the doctors can do is to bargain and made the best deal possible with their governments so as to save the remnants of what was once a free profession."

Let us keep eternally vigilant so that we and our successors may always be fortunate to live in America, the land of the free.

Patient's Judgment on Medical Emergency Verified

The 24 hour emergency call plans, sponsored by many county medical societies across the nation, represent a widely recognized milestone of progress in medicine's relations with the public. Nevertheless, there are those who question the need for establishing such service on the ground that the layman does not recognize a medical emergency when confronted with one except in major accident cases.

Of particular interest is a recent evaluation of medical emergency service by the Director of Doctor's Emergency Service provided by the Medical Society of the County of New York.[1] The volume of its service is probably the greatest in the country and the service is expertly handled. The thorough follow-up system concerning diagnosis and disposition of each case includes information on the original emergency request, the time of the call, the patient's statement of the illness, and the names of the physicians contacted in rotation until one accepts the call. Also, within one week the physicians on the emergency panel must file a diagnosis and disposition report on each case. When the patient names a family physician whom he cannot reach, that physician is protected by transmission of this information to him for follow-up purposes.

Analysis of 2,461 consecutive "emergencies" met over a period of approximately eight months justified the patient's judgment as to the seriousness of his illness. The number of hypochondriacs or persons with trivial requests for emergency medical care did not prove to be excessive. The emergency calls were greatest in number between 9 p.m. and 2 a.m. and occurred with greatest frequency on weekends and holidays, as would be expected.

In this series, the types of illness reported by the attending physician were respiratory, 23 per cent; gastrointestinal, 20 per cent; neurologic, 13 per cent; cardiac, 12.7 per cent; accidents, 8.5 per cent; miscellaneous, 5.7 per cent; obstetric-gynecologic, 5.5 per cent; alcoholic, 3.9 per cent; pediatric, 3.3 per cent; surgical, 1.3 per cent; and drug addiction, 1.1 per cent. Thirty-two patients, or 1.3 per cent, were dead when the physician arrived.

This study, made in a county in which during the calendar year 1951 some 4,500 house calls were made by 250 physicians of the Doctor's Emergency Service panel and involved over 18,000 telephone calls, points up the value of such service and emphasizes the importance of this most useful public service wherever it is provided.

1. Potter, R. D.: What Is a Medical Emergency? J. A. M. A. 150:1095-1096 (Nov. 15) 1952.

Civil Defense Manual on Matching Funds Program

A guide for state and local civil defense officials in getting matching federal funds for health, special weapons, and other protective programs has been issued by the Federal Civil Defense Administration. "Federal Contributions, M 25-1" is the title of the publication which makes known that the rigid procedure for approving state requests under the 30 million dollar civil defense supply and equipment program has been eased. Hereafter the Federal Civil Defense Administration will give wider latitude to state plans.

This manual sets forth regulations applicable to various programs and criteria for approving project requests. It recommends specific medical supplies and equipment for a first aid station, for ambulance and litter-bearer groups, for a 200-bed improvised hospital, and for blood donor operations. In addition, it sets forth legal and policy limitations and procurement procedures.

The last Congress voted 15 million dollars for the matching funds program, of which $270,000 was allocated to Florida. With the states providing an equal amount, the over-all program would total 30 million dollars. There is available also nearly 34 million dollars which the FCDA is using for an all-federal blood plasma (serum albumin) stockpiling project.

The criteria established for the matching programs are: 1. Medical supplies and equipment (except blood donor equipment) must be stored in critical target areas or within a radius of about 50 highway miles from the nearest boundary of such areas. 2. Target area states must provide at least 50 per cent of their requirements for first aid systems before consideration can be given to requests for other health items. 3. Medical supplies and equipment will be limited to standard items listed in the manual, and they may be used for training purposes only when such training does not jeopardize their ready availability in good condition when needed.

States will receive no contributions for supplies and equipment for training purposes, the FCDA makes clear, when they are available from

(1) first aid courses given by the American Red Cross and the U. S. Bureau of Mines, (2) the 80-hour course of the Red Cross for volunteer nurses aides, or (3) hospital training courses that can be given in existing hospitals. In the foreword, Acting Civil Defense Administrator J. J. Wadsworth declares that if each state and community "uses available matching funds to achieve a balanced pattern of civil defense, the end result will be the most effective national civil defense program possible with available funds."[1]

1. Civil Defense Program, J. A. M. A. 150:13-14A (Dec. 20) 1952; Civil Defense Issues Detailed Manual on Matching Funds Program for States, Capital Clinic Vol. 3, No. 49 (Dec. 9) 1952. The manual is available at $1 a copy from the Government Printing Office, Washington 25, D. C.

Red Cross Finances Gamma Globulin Production

The American Red Cross has announced that it will assume the cost of producing all possible gamma globulin. In complying with the request of the Office of Defense Mobilization to finance extraction of gamma globulin from whole blood, the Red Cross refused to assume responsibility for allocation or distribution of the blood fraction, now recognized as effective in preventing paralysis in poliomyelitis victims, and stipulated that this supply of gamma globulin be furnished without charge to whatever distribution agency is selected, "in keeping with the policy now governing Red Cross distribution of blood and blood products."

Of particular interest to physicians is the problem of matching supply with demand. Next year's epidemics are expected to expose approximately 2 million children to the disease. There is little or no possibility, however, that the supply of gamma globulin will meet the demands when the poliomyelitis season reaches its height next summer, even with a seven day week and 24 hour day processing schedule.

The decision of the Red Cross to accelerate its blood procurement program and finance gamma globulin processing is effecting important changes in the Defense Department and Federal Civil Defense Administration blood stockpiling programs. Since both serum albumin and gamma globulin can be processed from the same whole blood, these agencies will begin storing serum albumin instead of blood plasma.

Gamma globulin will continue to be used for the treatment of measles and infectious hepatitis as well as for the prevention of paralysis in poliomyelitis, the Red Cross announcement stated.

The first organization to suggest a way of handling distribution was the Association of State and Territorial Health Officers. At its meeting in Washington soon after the Red Cross made its announcement, the association recommended that a central authority for allocation of the product be established immediately. In the resolution adopted it was requested that "adequate representation" be given the association on the central authority.[1]

1. Red Cross to Finance Production of Gamma Globulin, J. A. M. A. 150:13A (Dec. 20) 1952.

Denver A.M.A. Clinical Session

The Sixth Clinical Session of the American Medical Association, held in Denver, Dec. 2-5, 1952, was well attended and enthusiastically received. Meeting annually in December in cities and areas unable to accommodate the annual sessions, the midyear clinical sessions attract many members who do not attend the annual meetings, thereby bringing this great organization closer to its members. Also, they provide a unique opportunity for training the general practitioner and in many other ways have proved well worth while.

Numerically, the attendance was excellent for the area although well below that of the preceding year in Los Angeles. The total registration of 7,635 included some 2,800 physicians and more than 400 medical students. Approximately 600 nurses and more than 200 technicians were also present. The scientific exhibits numbered 60 and the technical exhibits 140. Participating in the scientific program were 200 physicians, whose papers covered a wide variety of interests.

These figures foreshadow what may be expected at the meeting in December of this year in St. Louis, and they offer a challenge to Miami, the host city for December 1954, not alone to exceed the Denver record but to aspire to the Los Angeles record. Plans are already under way for the Miami session. Facilities have been declared adequate, with the meetings taking place under one roof at Dinner Key where the large auditorium will accommodate the entire scientific assembly and exhibits and where a good restaurant and adequate parking space are available. The newly constructed Mercy Hospital nearby has suitable facilities for television, and the Jackson Memorial Hospital has resources adequate for clinical needs.

"A true son of Texas, whom not only Texans but all Americans can honor" was selected at the Denver session as the "General Practitioner of the Year." Dr. John Mastin Travis, 75 year old

family physician of Jacksonville, Texas, was the recipient of this honor. This devoted servant of medicine is a charter member of the American Academy of General Practice, which he helped to organize. A student of doctor needs in rural communities, he was one of the originators of a plan to permit medical graduates to serve their internships in small town hospitals. This prominent leader in civic affairs became outstanding in the promotion of public health and sanitation throughout the state. His colorful professional and civic background led to his choice for the award as "a man who exemplifies the best in our system of free enterprise, a leader in his community, respected and loved by his colleagues and the people he has served so well."

One of the numerous highlights of the session was the announcement by the Board of Trustees that it was making its third contribution of a half million dollars to the American Medical Education Foundation, organized in 1950 to help raise funds within the profession for hard-pressed medical schools. Another was the tremendous role of television in promoting public relations for American medicine. It was estimated that 35 million persons saw the 30 minute Tuesday night show from Denver and 50 million persons saw the 30 minute Thursday night show. It is noteworthy also that more than 400 persons, including many physicians, attended the fifth Medical Public Relations Conference the day before the meeting opened.

In his address to the House of Delegates, President Louis H. Bauer made numerous constructive suggestions as he dealt with public health facilities, voluntary health insurance plans, "commercialism" in the practice of medicine, and the disciplining of unethical members. He declared that even though medical schools today are turning out doctors at a rate faster than the population is increasing, something must be done to get more doctors in so-called isolated areas. "First," said he, "we must encourage communities to establish facilities for a doctor to practice good medicine and, second, we must recommend that our specialty boards revise their requirements.

"The present system results in more men going into the specialties of medicine than is desirable, as they realize that if they are ever to become specialists, they must begin their training immediately on graduation. The present system practically prevents a general practitioner from becoming a specialist. The best specialist is the one who has a background of general practice."

Dr. Bauer considered it desirable to provide for greater recognition of general practice as one of the requirements for at least the majority of special fields.

"Spirit Incorruptible"

Dr. Sarah Parker White of Boston, formerly of Tallahassee, has kindly reviewed for The Journal a recently published book believed to be of particular interest to the medical world. Now an honorary member of the Florida Medical Association, Dr. White was for 10 years an active member while she was on the staff of the Florida State College for Women. The review follows:

> WHEN DOCTORS ARE PATIENTS. Edited by Max Pinner, M.D., and Benjamin F. Miller, M.D. Cloth $3.95. Pp. 364. W. W. Norton, Inc., New York, 1952. This book will appeal equally to physicians and to intelligent laymen. The Journal of the American Medical Association under the heading of Correspondence, page 509, Feb. 17, 1951, presented both a preview of and a petition for contributions to the book which has now been published. It presents 33 autobiographic sketches all written by DOCTORS who ARE PATIENTS.
>
> The article headed Correspondence and published in 1951 stated that Dr. Max Pinner because of his many years of illness had become interested after observing "how much he had learned about his malady which did not appear in the usual medical text books. He also became fascinated by how much one learns about adaptation to a chronic illness. Dr. Pinner believed that his 'education' was not unique and that many other physicians who had experienced illness would have much to contribute." Accordingly, he began collecting autobiographic sketches from physicians with the idea of publishing a book. He died long before his work was finished, and Mrs. Pinner then asked his friend, Dr. Benjamin F. Miller of the Peter Bent Brigham Hospital in Boston to complete the work and see it through the press. Now out, it lives up to the hope of its two editors. It is a unique contribution to the understanding of disease on the physical, mental and emotional

levels. It will appeal to many groups. First of all to the sick, to laymen quite as much as to physicians. Then to the well. And finally to nurses, physiotherapists, occupational therapists, psychologists and psychiatrists.

Those who knew the late Dr. George M. Gould of Dictionary fame will be reminded of his saying:

> Every doctor ought to have a serious illness every two years. He and his patients would each profit much from the experience.

In an editorial entitled "Spirit Incorruptible," the New England Journal of Medicine in the issue of Oct. 30, 1952 also commends the book as "dignified and on the whole a successful setting down in black and white of the accounts of productive introspection," from whose pages lay readers, similarly afflicted, may find comfort or inspiration and physicians may learn, if not to heal themselves, at least how other physicians have faced up to like problems. It cites as possibly the clearest exposition of one's reaction to degenerative disease the closing sentences of Dr. Abraham Myerson's deposition, penned shortly before his death in 1948:

> In the bright sunshine of today, writing at my desk, I feel reasonably well, and though I would not bet that I shall live six months, it *seems* as if the real *I* is indestructible. I think psychiatrists preach nonsense when they say: "adjust to reality." We can only really endure life if we cherish healthy illusions, if we have faith no matter how fantastic, or the kind of healthy-mindedness that shakes off, as a dog shakes off water, the disagreeableness of now and the future.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Matthew E. Morrow, Jr., of Jacksonville announce the birth of a son, Matthew Edward, III, on Nov. 20, 1952.

Dr. and Mrs. Benjamin F. Streets of Pinellas Park announce the birth of a son, on Nov. 24, 1952.

Dr. and Mrs. Jack H. Bowen of Jacksonville announce the birth of a son, Jeffery Stephen, on Dec. 15, 1952.

Dr. and Mrs. Joseph Canipelli of Jacksonville announce the birth of a daughter, Adelaide, on Dec. 20, 1952.

Deaths — Members

Throne, Binford, Bradenton ..... Oct. 17, 1952

Blessing, Robert, Fort Lauderdale ..... Oct. 29, 1952

Deaths — Other Doctors

Abrams, Marc V., Miami Beach ..... Dec. 18, 1952

CORRESPONDENCE

Editor
Journal of the Florida Medical Association
Jacksonville, Florida

Dear Editor:

The following remarks are offered for whatever purpose they may serve, and to be published in The Journal if you see fit.

Doctors of Medicine, what's wrong with us? What's wrong with the present laws that govern the practice of medicine and surgery in this state? What's wrong with our public relations? What's in store for us in the future with reference to our profession and our patient following?

The answers to these questions are remote and at present unpredictable for too little thought has been given to them by us individually. However, in this past general election held November 4, the Osteopaths of Bay County, along with aid from a state and national level plus the political help of an Osteopathic student, dealt us physicians in this county much concern and certainly much food for thought by forcing upon us, through legislative action, an act to be decided by referendum vote of the people of Bay County. The Osteopaths were attempting by law to gain admittance to the staff of our county hospital with full staff privileges to practice medicine and surgery without restrictions; and to impose a penalty of fine and imprisonment, or both, for the violation of any part of their proposed law. This act was no doubt intended not only for personal gain and professional recognition but also as a test bill for this state, and, if successful, state wide legislation would undoubtedly have been attempted in the future. This act was conceived by the Osteopaths, drafted by clever lawyers, propelled through the legislature, in an effort to get it passed without a referendum. But, by quick and concentrated effort on our part to get the bill killed or withdrawn it finally came out of the legislative mill with a referendum attached. This was a challenge to find out from the people just how Doctors of Medicine stacked up against Doctors of Osteopathy in their opinions. A hot and intensive campaign on both sides was waged during the last two weeks before the election. All kinds of methods were used such as radio, newspaper, posters, pamphlets, loud speakers, personal talks, speeches, forums, personal letters, etc. We, Doctors of Medicine, won the election by a vote of near two

to one count, but had we not made a heroic effort to inform the people of the deception of the act and what it would do to the rating and standards of our hospital we would have been defeated. The wording of the act that appeared on the voting ballots was most deceiving and sounded good, and the average intelligent voter might have voted for this bill not realizing he was voting to allow Osteopaths on the staff, as the word Osteopath was nowhere mentioned in the act. The words "Physician and Surgeon" replaced the word "Osteopath" and according to the present laws was in order and legal. According to the interpretation of the present laws governing the practice of medicine and surgery in this state, the Osteopaths have every privilege afforded the M.D.s.

While we were victorious in our political fight with the Osteopaths we have nothing to brag about. With twenty-three Doctors of Medicine against two local Osteopaths and one Osteopathic student we were only able to win by less than two to one vote.

The significance of this proposed legislation for Bay County by the Osteopaths and the not too favorable vote to defeat it suggests to me the following items as food for thought for the Doctors of Medicine of Florida:

1. The Laws of Florida governing the practice of Medicine and Surgery need revising. No one but a Doctor of Medicine should be allowed to practice Medicine and Surgery on human beings without restriction, and surgical and radiological qualifications should be placed on M.D.s before they are allowed to practice these sciences unrestricted.
2. Osteopaths should be limited in their practice of Medicine and Surgery until they have become better educated and have training equal to that for M.D.s.
3. The M.D.s are self centered and are most lethargic to any endeavor other than to practice their profession. This perhaps is as it should be, but if we are to survive as the greatest profession on earth, we had better get on the ball, take inventory of ourselves and act accordingly.
4. This was a test bill, and if it had been successful similar legislation on a state wide level might have been attempted, and perhaps will yet be attempted.
5. Doctors of Medicine should improve their politics and public relations with the same effort and zest as they do their professional knowledge and skill, lest we get caught in a rip tide or slip into a maelstrom.

Think! Plan! Act! Or are you interested? I think you are.

(Signed) William C. Roberts, M.D.
Panama City, Florida
December 23, 1952

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Anderson, Clarence L., Lakeland
Garby, Rodes C., St. Petersburg
Hobach, John P., St. Petersburg
Lockwood, Raymond M., Clearwater
McEvoy, Joseph P., St. Petersburg
Norville, Wilbert O. (Col.), Belle Glade

THE SEVENTY-NINTH ANNUAL CONVENTION
of the
FLORIDA MEDICAL ASSOCIATION
HOLLYWOOD BEACH HOTEL APRIL 26-29,. 1953

STATE NEWS ITEMS

Four members of the Association were registered at the Clinical Session of the American Medical Association in Denver, December 2-5. They are delegates Drs. Louis M. Orr, II, Orlando; Herbert L. Bryans, Pensacola; and Homer L. Pearson, Jr., Miami; also in attendance was Herbert W. Virgin, Jr., of Miami.

Dr. Orr was chairman of the Reference Committee to the A.M.A. House of Delegates on Reports of Board of Trustees and Secretary, and Dr. Pearson is a member of the Judicial Council.

Seventeen county medical societies have participated in the showing of the film, "Your Doctor," to audiences in Florida. They are: Alachua, Brevard, Broward, Dade, Duval, Hillsborough, Lee-Charlotte-Collier-Hendry, Leon-Gadsden-Liberty-Wakulla-Jefferson, Madison, Manatee, Marion, Orange, Palm Beach, Pinellas, Sarasota, Seminole and Volusia. The film has been booked in 25 commercial theatres in these counties. Produced by RKO-Radio Pictures in cooperation with the A. M. A., the film is to be made available for showing in schools, and to civic and professional groups in the near future.

Dr. Wesley W. Wilson of Tampa has returned to his practice after attending the annual meeting of the American Academy of Dermatology in Chicago.

Dr. Arthur J. Butt of Pensacola was recently elected to membership in the New York Academy of Sciences (Section of Physics and Chemistry).

Mr. W. Harold Parham, Supervisor of the F.M.A. Bureau of Public Relations, attended the Fifth A.M.A. Medical Public Relations Conference in Denver, December 1, the day before the opening of the A.M.A. Clinical Session.

President Robert B. McIver of Jacksonville spoke at the regular meetings of the Dade County Medical Association on January 6 and the Escambia County Medical Society on January 13.

Dr. Sullivan G. Bedell of Jacksonville has been elected president of the Florida Association for Mental Health.

Members of the Florida Medical Association registered at the Southeastern Regional Meeting of the American College of Physicians in Havana, Cuba, Nov. 7-8, 1952 were Drs. J. Sudler Hood, Clearwater; Dale L. Groom, Coral Gables; Turner Z. Cason, Bernard J. McCloskey, and Louis M. Sales, Jacksonville; Jere W. Annis, Lakeland; Sidney Davidson, Lake Worth; Martin S. Belle, O. Whitmore Burtner, Robert F. Farrington, Morton M. Halpern, Louis Lemberg, and George F. Schmitt, Jr., Miami; Paul Plotkin, Nicholas A. Tierney, and Paul N. Unger, Miami Beach; Elwyn Evans, William H. Kelley, Fred Mathers, W. Dean Steward, Orlando; Charles K. Donegan, Norval M. Marr, H. Milton Rogers, and John P. Rowell, St. Petersburg; William C. Blake, Tampa; and W. Wellington George, Samuel A. Manalan, and Saul D. Rotter, West Palm Beach.

Dr. William C. Blake of Tampa is the governor for Florida on the Committee of Governors of the College.

Dr. Lucien Dyrenforth of Jacksonville took a course in Hematology under Dr. William Dameshek in Boston in December. The course was sponsored by the American College of Surgeons.

Dr. William C. Roberts of Panama City, who is a Founder Fellow of the American Academy of Obstetrics and Gynecology, attended the first scientific and clinical session of the organization held in Chicago December 15-17 at the Palmer House. Dr. Roberts also visited in Milwaukee, Chicago, Memphis and Mobile following the close of the Academy Convention.

Dr. Cornelia M. Carithers of Jacksonville spoke on "Teaching Our Children About Sex" at the November meeting of the Duval County Medical Auxiliary.

Drs. Orion O. Feaster and Annette M. Feaster of Renton, Wash. were recent visitors in St. Petersburg.

Dr. Edward R. Annis of Miami was principal speaker at a recent luncheon meeting of the Republican Club of Greater Miami.

Dr. Reuben B. Chrisman, Jr., of Miami represented the American Medical Association in Havana recently when one of the great victories of medical science, the conquest of yellow fever, was commemorated.

Dr. John T. Stage of Jacksonville attended a meeting of the Florida Blood Banks Society in Miami in December. Dr. Stage is vice president of the Society.

Dr. Joseph W. Scott of Miami announces the removal of his office to 742 duPont Building with practice limited to obstetrics and gynecology.

Dr. Dale L. Groom of Coral Gables announces the removal of his office to suite 606 duPont Building with practice limited to cardiovascular diseases.

Dr. O. Whitmore Burtner of Miami spoke on "Triethylene Melamine in the Treatment of Lymphomas;" Dr. Dale L. Groom of Coral Gables spoke on "Cholesterol, Lipoproteins, and Atherosclerosis: Present Concepts;" and Dr. H. Milton Rogers of St. Petersburg spoke on "The Diagnosis of Congenital Cardiac Anomalies as Seen by the Internist," on the scientific program of the Southeastern Regional Meeting of the American College of Physicians in Havana, Cuba, Nov. 7-8, 1952.

Dr. J. Brown Farrior of Tampa has returned to his practice after attending the meeting of the First Central American Congress of Otorhinolaryngology in San Salvador, where he delivered a paper. He also visited in Managua, Nicaragua and Costa Rica. He presented another scientific paper in San Jose, Costa Rica.

Dr. Claude C. Pearce of Mulberry was honored for 34 years of service to his community recently. A day was set aside as Dr. Pearce Appreciation Day and a picnic was held.

Dr. Sherman B. Forbes of Tampa recently attended the annual meeting of the New England Society of Ophthalmology in Boston.

Dr. Maurice M. Greenfield of Miami has returned to his practice after attending the 38th Annual Meeting of the Radiological Society of North America in Cincinnati.

Dr. John M. Malone of Green Cove Springs, who has returned to active duty in the Navy, was honored with a testimonial dinner by the Chamber of Commerce of Green Cove Springs before his departure.

Dr. Homer L. Pearson, Jr., of Miami has been reappointed to a 4-year term on the State Board of Medical Examiners by Governor Warren.

The American Medical Association's popular "Today's Health" (formerly "Hygeia") is being sent by the Florida Medical Association again this year to all state senators and representatives, the governor and other state officials in Tallahassee. In addition, it goes to Florida's two senators and eight representatives in Washington with the Association's compliments.

Dr. Joseph C. Hayward, formerly of Orlando, a member of the Orange County Medical Society, announces the opening of his office for the practice of Urology in San Diego, Calif.

Dr. Joseph E. Thomas of Miami entered active military service with the U. S. Air Force on Nov. 16, 1952, with the rank of First Lieutenant.

The March issue of your Journal will contain the complete program of the Seventy-Ninth Annual Meeting of the Association to be held in Hollywood, April 26-29, 1953.

The Dade County Medical Association has announced that Mr. John C. Lee of Miami has accepted an appointment as full-time executive secretary effective January 16.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

LOCATION DESIRED: Internist, Board diplomate, F.A.P.C., age 49, desires association with physician. Especially qualified in cardiology and metabolic diseases. Prefers West Coast location. Florida license. Write 69-76, P. O. Box 1018, Jacksonville, Florida.

LOCATION DESIRED: Internist, experienced director of clinical laboratory desires position in small hospital. EKG interpretation and consultation. Florida license. Write 69-77, P. O. Box 1018, Jacksonville, Fla.

LOCATION DESIRED: 29 year old internist, University trained. Board qualified. Florida license. Desires location or affiliation after completing Army service in September 1953. Write 69-78, P. O. Box 1018, Jacksonville, Fla.

COMPONENT SOCIETY NOTES

Alachua

New officers of the Alachua County Medical Society are Dr. F. Emory Bell, president; Dr Henry H. Graham, president-elect; and Dr. Winston L. Summerlin, secretary-treasurer, all of Gainesville.

Bay

At the regular monthly meeting of the Bay County Medical Society, officers for 1953 were elected as follows: Dr. Harold E. Wager, president; Dr. Joseph H. Morris, vice president; Dr. Charles H. Daffin, secretary; and Dr. Sidney E. Daffin, treasurer, all of Panama City.

Brevard

At the regular December meeting of the Brevard County Medical Society officers were elected for the year 1953. Dr. Laurent L. LaRoche of Cocoa was elected president; Dr. Theodore J. Kaminski of Melbourne was elected vice president; and Dr. Allen E. Kuester of Cocoa was elected secreary-treasurer.

Broward

The new officers of the Broward County Medical Association are Dr. Claus A. Peterson, president, and Dr. Julius F. Boettner, president-elect, both of Fort Lauderdale; Dr. Ernest E. Serrano, vice president, Hollywood; Dr. James M. Weaver, secretary, and Dr. William D. Wells, treasurer, both of Fort Lauderdale.

Columbia

Dr. Robert B. Harkness of Lake City was re-elected president of the Columbia County Medical Society for 1953. Also re-elected were Dr. Laurie J. Arnold, Jr., vice president, and Dr. Thomas H. Bates, secretary-treasurer, both of Lake City.

Drs. William C. Croom and Nathan Weil, Jr., of Jacksonville spoke on skin diseases common to childhood and their present day treatment at the annual meeting of the Society on December 13, in Lake City.

The Columbia County Medical Society's transcribed program on station WDSR, Lake City, has been changed from a weekly to a twice a week broadcast. The program can now be heard each Tuesday and Thursday at 6:30 p.m. A. M. A. transcriptions from the F. M. A. Bureau of Public Relations are being used for the programs.

Dade

Dr. Ralph W. Jack of Miami will serve as president of the Dade County Medical Association for 1953. Other officers elected at the regular December meeting include: Dr. Edward W. Cullipher, president-elect; Dr. Hunter B. Rogers, vice president; and Dr. Walter W. Sackett, Jr., secretary, all of Miami. Dr. Raymond L. Evans of Miami was re-elected treasurer.

At the January meeting of the Dade County Medical Association, Dr. Dale L. Groom spoke on "Cholesterol Lipoproteins in Atherosclerosis."

Guest speaker at this meeting was Dr. Robert B. McIver, of Jacksonville, F. M. A. president.

DeSoto-Hardee-Highlands-Glades

Officers elected to serve the DeSoto-Hardee-Highlands-Glades County Medical Society for 1953 are Dr. Wesley S. Pyatt, president, of Bowling Green; and Drs. Roland W. Banks, vice president, and Merle C. Kayton, secretary-treasurer, both of Wauchula.

Dr. Joseph W. Taylor, Jr., of Tampa was guest speaker at the December meeting of the Society. He spoke on "Common Eye Conditions Seen in Office Practice."

Duval

At the regular December meeting of the Duval County Medical Society the 1953 officers were elected. They are Dr. W. W. Rogers, president; Dr. Karl B. Hanson, president-elect; Dr. John T. Stage, secretary; and Dr. Sidney Stillman, treasurer. All of these officers are from Jacksonville.

At the January meeting of the Society, Dr. Ashbel C. Williams spoke on "Management of Cardiac Arrest."

Escambia

At a meeting of the Escambia County Medical Society on December 9, the following officers were elected for 1953: Dr. Alvin L. Stebbins, president; Dr. Wilson E. Tugwell, president-elect; Dr. Frank E. Tugwell, vice president; and Dr. Paul F. Baranco, secretary-treasurer. All the officers are from Pensacola.

President Robert B. McIver of Jacksonville was guest speaker at the meeting of the Escambia County Medical Society on January 13.

Hillsborough

New officers of the Hillsborough County Medical Association are Drs. Arthur R. Knauf, president; C. Frank Chunn, president-elect; Herbert B. Lott, vice president; Julien C. Pate, Jr., secretary; and Arthur J. Wallace, treasurer, all of Tampa.

At the January meeting of the Society, a program on "Civil Defense" was held with Dr. William W. Trice, Jr., as moderator.

Indian River

At the regular December meeting of the Indian River County Medical Society, the following officers were elected: Dr. John P. Gifford, president, and Dr. James C. Robertson, vice president, both of Vero Beach. Re-elected secretary-treasurer was Dr. William L. Fitts, 3rd, also of Vero Beach.

Jackson-Calhoun

Officers for the Jackson-Calhoun County Medical Society for 1953 are Dr. Grayson C. Snyder, president, Blountstown; and Drs. William R. Wandeck, vice president, and Francis M. Watson, secretary-treasurer, both of Marianna.

Lake

The list of officers who will serve the Lake County Medical Society during 1953 appeared in the January Journal.

Lee-Charlotte-Collier-Hendry

The newly-elected officers of the Lee-Charlotte-Collier-Hendry County Medical Society are Drs. Ernest Bostelman, president, Curtis R. House, vice president, and Fred D. Bartleson, secretary-treasurer, all of Fort Myers.

Leon-Gadsden-Liberty-Wakulla-Jefferson

New officers of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society are president, Dr. Charles F. James, Jr., of Tallahassee; vice president, Dr. George H. Massey of Quincy; and secretary-treasurer, Dr. T. Bert Fletcher, Jr., of Tallahassee.

Madison

New officers of the Madison County Medical Society are Dr. Julian M. DuRant of Madison, president, and Dr. A. Franklin Harrison of Madison, secretary.

Manatee

Officers of the Manatee County Medical Society for 1953 are president, Dr. William D. Sugg; vice president, Dr. George B. Clark; and secretary-treasurer, Dr. Marjorie L. Warner, all of Bradenton.

Marion

At the regular December meeting of the Marion County Medical Society, Dr. Eugene G. Peek, Jr., was elected president for 1953. Dr. John D. Lindner was elected vice president, and Dr. Bertrand F. Drake was re-elected secretary-treasurer. All three officers are from Ocala.

Monroe

Officers of the Monroe County Medical Society for 1953 are Drs. Joseph L. G. Lester, Jr., president, Herman K. Moore, vice president, and Allen S. Shepard, secretary-treasurer, all of Key West.

Dr. Luther R. Leader, President of the Academy of Surgery of Detroit, spoke on diseases of the colon and their treatments at a recent joint meeting of the Monroe County Medical Society and the medical staff of the Naval Hospital in Key West.

Nassau

Dr. David G. Humphreys was re-elected president of the Nassau County Medical Society for 1953. Also re-elected were Dr. Benjamin F. Dickens, vice president, and Dr. John W. McClane, secretary-treasurer. All three officers are from Fernandina.

Orange

The newly-elected officers of the Orange County Medical Society are: Drs. G. Tayloe Gwathmey, president, Eugene L. Jewett, president-elect, William S. Mitchell, vice president, Andrew W. Townes, Jr., secretary, and Fred H. Albee, Jr., treasurer, all of Orlando.

The Orange County Medical Society has secured space at the Central Florida Exposition, Orlando, and will show the Florida Medical Association's Fair Exhibit there Feb. 23-28, 1953, according to announcement by Dr. Chas. J. Collins, Orlando, Chairman of the Society's Committee on Public Relations. More than 100,000 persons are expected to attend the Exposition.

(Continued on page 610)

Dramamine® in Vertigo

The remarkable relief afforded by Dramamine in motion sickness has led to studies of its possible value in allied conditions.

Dramamine apparently depresses hyperstimulation of the vestibular apparatus. Thus it is an effective means of relieving the nausea and vertigo which characterize dysfunctions of the middle ear.

Accepted Uses for Dramamine

(BRAND OF DIMENHYDRINATE)

MOTION SICKNESS

NAUSEA and VOMITING associated with
- pregnancy
- drugs (certain ontibiatics, etc.)
- electroshock theropy
- narcotization

VESTIBULAR DYSFUNCTION associated with
- streptomycin therapy

VERTIGO in
- Ménière's syndrome
- hypertensive disease
- fenestration procedures
- labyrinthitis
- radiation sickness

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SEARLE *Research in the Service of Medicine*

Rx

...FOR BOTH DOCTOR AND PATIENT

• The name Sealtest is your guarantee of rich, wholesome dairy foods—healthful refreshment at its nourishing best.

Southern Dairies
Sealtest
ICE CREAM

(Continued from page 608)

The two attractions — blood pressure and blood typing — are to be offered with the showing of the exhibit. Dr. George R. Kerr, Orlando, will be in charge of blood typing and Dr. W. Dean Steward, Orlando, will supervise blood pressure.

Student nurses from Orange Memorial Hospital and the Florida Sanatarium and Hospital are to check pressures and technicians from the Central Florida Blood Bank and local clinical laboratories will type blood. The technicians will be assisted by members of the Woman's Auxiliary to the Society.

Palm Beach

Dr. Graham W. King, Jr., of Delray Beach is the newly-installed president of the Palm Beach County Medical Society. Elected to office were Dr. Thomas E. Daly, president-elect, West Palm Beach; Dr. David W. Martin, vice president, West Palm Beach; and Dr. Russell D. D. Hoover, treasurer, Palm Beach. Re-elected was Dr. David A. Newman of West Palm Beach, secretary.

Pasco-Hernando-Citrus

At the regular December meeting of the Pasco-Hernando-Citrus County Medical Society, Dr. Karl T. Humes of Bushnell was elected president of the Society. Drs. Harry G. Brownlee of Zephyrhills and Jere W. Kirkpatrick of Inverness were elected vice presidents, and Dr. W. Wardlaw Jones of Dade City was re-elected secretary-treasurer.

Pinellas

The list of officers who will serve the Pinellas County Medical Society during 1953 appeared in the December Journal.

The Pinellas County Medical Society has scheduled its second annual series of Medical Forums. The 1953 Forums, one hour long, will run from January through March and will be presented each Thursday. In cooperation with the St. Petersburg Times, the Society is selecting topics for discussion.

At the regular meeting of the Society in January, the guest speaker was Dr. Gerald H. Pratt, Chief of Vascular Surgical Service and General Surgery Clinic, New York Post-Graduate Hospital.

Polk

At its regular meeting in December, the Polk County Medical Society held its annual election of officers. Elected were Dr. Jere W. Annis, president, Dr. Samuel J. Clark, vice president, and Dr. James T. Shelden, secretary-treasurer, all of Lakeland.

Putnam

Dr. Bernard E. Kane of Cresent City is the new president of the Putnam County Medical Society, and Dr. James A. Long, Jr., of Palatka is secretary-treasurer.

The Putnam County Medical Society's exhibits at the Putnam County Fair in Palatka Dec. 11-13, 1952, attracted considerable attention. The exhibits graphically depicted "Diseases Transmitted From Animals to Man" and "How Disease Bacteria are Spread." Under the supervision of Dr. Lawrence G. Hebel of Palatka, then president of the Society, the displays were set up back to back in a 24-foot square space. The A. M. A. publication "A Doctor For You" and four health dodgers were distributed. No accurate check of the number of persons visiting the exhibits was available. The Fair, primarily a showing of the agricultural and manufactured products of Putnam County, was open to the public without charge.

St. Johns

At its regular meeting in December, the St. Johns County Medical Society held its annual election of officers. Dr. John M. Canakaris of Bunnell is the president, and other officers are Drs. George C. Hopkins, vice president; James J. DeVito, secretary, and Reddin Britt, treasurer, all of St. Augustine.

St. Lucie-Okeechobee-Martin

Dr. John T. McDermid is the new president of the St. Lucie-Okeechobee-Martin County Medical Society, and Dr. Laurance D. Van Tilborg is the vice president. Both are from Fort Pierce. Re-elected secretary-treasurer of the Society for 1953 was Dr. Adrian M. Sample, also of Fort Pierce.

Sarasota

Dr. Cecil E. Miller of Sarasota is the new president of the Sarasota County Medical Society. Other officers are Dr. Henry J. Vomacka, vice president and president-elect; Dr. Melvin M. Simmons, secretary; and Dr. Millard B. White, treasurer, all of Sarasota.

Advertisement

From where I sit *by* Joe Marsh

Bunny's Story Had a Nice "Ring" to It

"Bunny" Baker—our cute blonde secretary over here at the newspaper—showed up late for work the other morning and "scooped" us all.

Bunny came in carrying a big box of cigars under her arm and, without a word, went around dropping a cigar off at each desk. Finally, when we were all but bursting with curiosity, Bunny told us what was going on. She held up her left hand and proudly displayed a lovely diamond ring on her third finger.

"It's a boy," she said. "Six feet two, a hundred ninety-six pounds."

From where I sit, Bunny's way of announcing her engagement showed real ingenuity. And ingenuity—doing things in a better and different way—is a typical American trait. Freedom of expression, freedom to work how and where we please . . . even a little thing like the freedom to choose a glass of beer after a day's work—these are some things that make our nation so "engaging."

Joe Marsh

Copyright, 1952, United States Brewers Foundation

S. A. Kyle *Funeral Director*

MEMBER National Selected Morticians BY INVITATION

17 WEST UNION STREET
JACKSONVILLE 2, FLORIDA
Phones 5-3766 5-3767

THE MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899

specialized service
assures *"know-how"*

ST. PETERSBURG Office:
Calvin Bimer, Rep.,
240 Mateo Way, Snell Isle,
Telephone 73-289

Seminole

Newly-elected officers of the Seminole County Medical Society are Dr. Wade H. Garner, president, and Dr. Harry Z. Silsby, vice president, both of Sanford. Dr. Frank L. Quillman, also of Sanford, was re-elected secretary-treasurer.

Suwannee

Dr. Hiram B. Curry of Jasper is the new president of the Suwannee County Medical Society; Dr. William P. Blackmon of Mayo is vice president; and Dr. Edward G. Haskell, Jr., of Branford is secretary-treasurer.

The Suwannee County Medical Society's radio program on station WNER, Live Oak, was one year old in December. A. M. A. transcriptions from the record library of the F. M. A .Bureau of Public Relations are being used for the broadcasts. The program was begun under the supervision of Dr. J. Dillard Workman, Live Oak, then Chairman of the Society's Committee on Public Relations. Dr. Edward G. Haskell, Branford, 1952 President of the Society, has been in general charge of the broadcasts.

Volusia

Officers of the Volusia County Medical Society for 1953 were elected at the December meeting. Dr. Morris B. Seltzer of Daytona Beach was elected president, and Dr. William R. Hutchinson of DeLand was elected vice president. Dr. Robert L. Miller of Daytona Beach was re-elected secretary-treasurer.

Walton-Okaloosa

The officers of the Walton-Okaloosa County Medical Society for 1953 are Dr. Edgar H. Myers, DeFuniak Springs, president; Dr. Robert von P. Maxon, Fort Walton, vice president; and Dr. William D. Cawthon, DeFuniak Springs, secretary-treasurer.

• In MIAMI
SANITARIUM
Medical Hospital American Plan
Hotel for Patients and their families.
REST, CONVALESCENCE, ACUTE and
CHRONIC MEDICAL CASES. Elderly
People and Invalids. *FREE Booklet!*

Acres Tropical Grounds, Delicious Meals,
Res. Physician, Grad. Nurses, Dietitian.
Mild Mental Cases,
Drug and Alcoholics
in Separate Building

SUN-RAY PARK HEALTH RESORT

OBITUARIES

Wilson Cyrus Pay

Dr. Wilson Cyrus Pay died at his home in DeLand on Aug. 12, 1952, following a short illness. He was 81 years of age.

Born at North Royalton near Cleveland, Ohio, on Sept. 28, 1870, Dr. Pay attended schools in Cleveland and later Berea College before entering the University of Louisville School of Medicine. In 1894 he was awarded the degree of Doctor of Medicine by that institution.

Actively engaged in the practice of medicine for 56 years, Dr. Pay first practiced for more than three decades in Bellefontaine in his native state and for two years was secretary of the Logan County Medical Society there. In 1925 he came to Florida to reside and for nearly 20 years continued to practice his profession in DeLand. Because of his wife's ill health, he then moved to Hendersonville, N. C., where he practiced until his retirement in 1950 at the age of 79. For the past two years he had again resided in DeLand.

Dr. Pay was a member of the Volusia County Medical Society, at one time serving as secretary for two years. He also held membership in the Florida Medical Association and the American Medical Association.

Surviving are the widow, Mrs. Minnie D. Pay; one son, Gerald Pay of DeLand; and two daughters, Mrs. C. H. Dentler of DeLand and Mrs. M. M. Hanenkrat of Oxford, Pa.

Mac Millar Harrison

Dr. Mac Millar Harrison of Bradenton died on Aug. 16, 1952 at the family residence in Palmetto after a long illness. He was 66 years of age.

A native and lifelong resident of Manatee County, Dr. Harrison was the son of Dr. Micajah Berry Harrison and Cassie Millar Harrison. He was born in Oak Hill, now known as Parrish. Upon graduation from Furman University at Greenville, S. C., in 1905, he attended the University of North Carolina School of Medicine for two years and in 1911 was graduated from

Cook County Graduate School of Medicine

POSTGRADUATE COURSES — 1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting February 2, February 16, March 2. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 2. Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 16. Basic Principles in General Surgery, Two Weeks, starting March 30. Gallbladder Surgery, Ten Hours, starting April 20. Surgery of Colon & Rectum, One Week, starting March 2. General Surgery, One Week, starting February 9. General Surgery, Two Weeks, starting April 20. Fractures & Traumatic Surgery, Two Weeks, starting March 2.

GYNECOLOGY—Intensive Course, Two Weeks, starting February 16. Vaginal Approach to Pelvic Surgery, One Week, starting March 2.

OBSTETRICS—Intensive Course, Two Weeks, starting March 2.

PEDIATRICS—Intensive Course, Two Weeks, starting April 6. Congenital Heart Disease, Two Weeks, starting May 18.

MEDICINE—Intensive General Course, Two Weeks, starting May 4. Electrocardiography & Heart Disease, Two Weeks, starting March 16. Allergy, One Month and Six Months, by appointment.

UROLOGY—Intensive Course, Two Weeks, starting April 13. Ten-Day Practical Course in Cystoscopy starting every two weeks.

DERMATOLOGY—Intensive Course, Two Weeks, starting May 11.

Teaching Faculty:
Attending Staff of Cook County Hospital

Address:
Registrar, 707 South Wood Street,
Chicago 12, Illinois

BISCAYNE HOSPITAL

6339 Biscayne Blvd.
MIAMI 38, FLORIDA

Members of the Dade County Medical Association are acquainted with the high type of service rendered.

David Collins, Superintendent

Registered, American Medical Association
Phone 7-4544

Allen's Invalid Home

MILLEDGEVILLE, GA.

Established 1890
For the treatment of
NERVOUS AND MENTAL DISEASES

Grounds 600 Acres
Buildings Brick Fireproof
Comfortable Convenient
Site High and Healthful

E. W. ALLEN, M.D., *Department for Men*
H. D. ALLEN, M.D., *Department for Women*
Terms Reasonable

Janet's Nursery for Babies
P. O. Box 191
OSPREY, FLORIDA
Phone RIngling 4-1647

A Nursery for Handicapped Babies

For Information write
H. KEITH JACOBUS
P. O. Box 191
Osprey, Florida

the Tulane University of Louisiana School of Medicine.

Dr. Harrison was a veteran of World War I, serving with the Army Medical Corps in Europe. He entered the service as a first lieutenant and held the rank of major when released to inactive duty. Remaining in France after the cessation of hostilities, he attended the University of Toulouse, where he took a medical course taught only in French.

Upon his return from Europe, Dr. Harrison resumed the general practice of medicine in Manatee County. At first he maintained offices in Palmetto and later in Bradenton, where he continued to practice until failing health forced his retirement several months before his death. At the time of his death, he was County Physician, a position he had held for many years. He was a member of the Palmetto Baptist Church.

Dr. Harrison was a member and a past president of the Manatee County Medical Society. For more than three decades he had been a member of the Florida Medical Association, and he also held membership in the American Medical Association.

Surviving are the widow, Mrs. Allison Pugh Harrison; two daughters, Mrs. Allan D. Dodson, Hogansville, Ga., and Mrs. Robert Hartin, Monterey, Calif.; and one grandson.

James Martin Anderson

Dr. James Martin Anderson of Cross City died at Mercy Hospital in Miami on Oct. 5, 1952 after a long illness. He was 72 years of age. Interment took place in the Cross City Cemetery.

Born in Anderson, S. C., in 1880, Dr. Anderson came to Florida from Mona, Ark., in 1908. He received his medical education in Georgia,

MIAMI RETREAT SANATORIUM

FOUNDED 1927

For Nervous and Mental Disorders, Alcohol and Drug Addiction

STAFF OF EIGHT NEUROPSYCHIATRISTS
New X-Ray Diagnostic Treatment Facilities
Comfortable AIR-CONDITIONED rooms, suites

79TH STREET AT MIAMI AVENUE
MIAMI 38, FLORIDA
Phone 7-1824

where he was awarded the degree of Doctor of Medicine by Emory University School of Medicine in 1910.

He engaged in the general practice of medicine in Lafayette County as an associate of Dr. O. S. Greene before locating in Dixie County in 1929. For many years he was the only physician in Dixie County and during the years that he practiced there delivered more than 3,600 babies.

Particularly active in civic affairs, Dr. Anderson was known as the father of the Cross City water system. He was a pioneer of the Dixie County Health Unit, a former mayor, and a past president of the City Council. He was a member of the Presbyterian Church, but for a number of years taught an adult Sunday School class in the Methodist Church.

Dr. Anderson was a member of the Alachua County Medical Society. For more than a quarter of a century he held membership in the Florida Medical Association and he also was affiliated with the American Medical Association.

Surviving are the widow, the former Ola Sears of Mayo; two sons, Dr. Lumas Anderson of Miami and Mac Anderson of Fernandina; one sister, Mrs. Clifford McCarthy of Los Angeles, Calif.; and two grandchildren.

Charles Stacy Early

Dr. Charles Stacy Early of Lakeland died at Morrell Memorial Hospital in that city on Nov. 20, 1952. He was 74 years of age.

Dr. Early received his medical education in Cincinnati at Miami Medical College, now the Medical Department of the University of Cincinnati. He was awarded the degree of Doctor of Medicine in 1909 and immediately thereafter served one year as an intern in St. Mary's Hospital in Cincinnati.

He then entered the private practice of medicine at West Union, Ohio, later going to Portsmouth in the same state, where he practiced for six years. In 1919, Dr. Early came to Florida and for 30 years engaged in general practice in Lakeland. In December 1949 he retired from active practice.

Locally, Dr. Early was a member of the First Methodist Church. He was also affiliated with Lakeland Lodge No. 91, F & AM.

THE
EARLE JOHNSON SANATORIUM,
AND ANNEX

Caring for nervous and mental cases, alcoholism, addictions, etc., the most advanced psychiatric methods known here produce extraordinary results.

Operated by the Psychiatrist-in-Chief, C. Earle Johnson, Jr., M.D., F.A.P.A., F.A.C.P., Diplomate of the American Board of Psychiatry and Neurology, and Associates.

The hospital atmosphere is avoided. Fire-proof buildings. Swimming pool. Lovely gardens and grounds. Healthful location. All private rooms. Excellent Staff. Food of Distinction.

Brochure furnished upon request.

Write: Drawer 106. Telephone: 3-3369
3-3360

Member of the National Association of Private Psychiatric Hospitals

MERIDIAN, MISSISSIPPI

CONVENTION PRESS

218 WEST CHURCH STREET
JACKSONVILLE
FLORIDA

Commercial and
Publication
Printing

BRAWNER'S SANITARIUM
Established 1910

SMYRNA, GEORGIA
(Suburb of Atlanta)

For Nervous and Mental Disorders
Drug and Alcohol Addiction
Electro-Shock in selected cases

JAMES N. BRAWNER, M.D., Medical Director
ALBERT F. BRAWNER, M.D., Department for Men
JAMES N. BRAWNER, JR., M.D., Department for Women

Dr. Early was a member of the Polk County Medical Society. In 1935 he became a member of the Florida Medical Association and for the last two years had held honorary status. He was also a member of the American Medical Association.

Surviving are two nephews, Carl Early and Walter H. Early, both of Lakeland; four nieces, Mrs. Alma Maddox and Mrs. Virginia Marks, also of Lakeland; Mrs. Katherine Cameron of Auburndale and Mrs. Ellen Heck of Babbitt, N. Y. Two sisters-in-law, Mrs. Nell I. Early and Mrs. Mary Etta Early, both of Lakeland, also survive.

Charles Augustus Clemmer

Dr. Charles Augustus Clemmer of Ormond Beach died at his home on Nov. 3, 1952. He was 71 years of age. Interment took place in Keene, N. H.

Born in Augusta County, Virginia, on March 5, 1881, Dr. Clemmer received his education in his native state. He attended Hampden Sidney College at Hampden Sidney and the University College of Medicine, now the Medical College of Virginia, at Richmond, where he was awarded the degree of Doctor of Medicine in 1907.

From 1907 until 1912 Dr. Clemmer engaged in the general practice of medicine in Randolph and Pocahontas counties in West Virginia and then practiced in Weirton, W. Va., until 1918. At that time he entered military service as a captain in the Medical Corps of the Army.

Upon discharge from the service in 1919, Dr. Clemmer located in the Daytona Beach area and continued in general practice there for more than a quarter of a century. He was a member and a past president of the Volusia County Medical Society. For 28 years he held membership in the Florida Medical Association, with honorary status for the last five years, and was also a member of the American Medical Association. For some time he served as chief of staff at the Halifax District Hospital.

Doctor, Journal Advertisers

Merit and Appreciate

Your Patronage

BOOKS RECEIVED

Living with Cancer. By Edna Kaehele. Pp. 160. Price, $2.00. Garden City, N. Y., Doubleday & Company, Inc., 1952.

Appropriately advertised as the true story of a woman who refused to die, this account of the author's battle with cancer to the brink of death and back again to normal life despite continuing activity of the malignant lesion makes fascinating reading for the well reader. To the victim of this dread disease it breathes inspiration, courage, comfort and guidance which could only be imparted out of grim experience by means of a facile pen from an understanding heart.

The physician who pauses to scan the little volume will gain insight into the patient's viewpoint and a lesson in psychosomatic medicine which may enable him to be more helpful to patients who must live with cancer for an indeterminate period. Says the author, "In their desperate effort to waken people to the chances of a cure in the earliest stages of cancer, medical men have unintentionally given people a hopeless attitude toward it. For the unhappy truth is that most cancers are not discovered in these early stages. So, if the patient hears 'six months' he never even thinks to look beyond the prescribed time, but obligingly lies down and dies on schedule." Her allotted "six months" have now lengthened into the sixth year.

How this courageous young mother of four children learned one step at a time to live with cancer and today, after five years, is firm in her conviction that "I am more important than any foreign growth occupying my body," is inspirational reading which could be invaluable to those who need it most.

Physician's Handbook. By Marcus A. Krupp, M.D., Norman J. Sweet, M.D., Ernest Jawetz, Ph.D., M.D., and Charles D. Armstrong, M.D. Ed. 7. Pp. 380. Price, $2.50. Los Altos, Calif., University Medical Publishers, 1952.

For the eleventh year, this Handbook, now in its seventh edition, offers a readily available source of factual data, laboratory procedures, and clinical aids repeatedly used in all branches of medicine. The volume is designed as a handy pocket-reference for both student and physician. With the introduction of new material it became apparent that some of this material required elaboration. Thus, the volume presents a mixture of terse listing of factual data and informal discussion. In this edition most of the sections have been thoroughly revised and often expanded. Further emphasis has been given to basic principles which aid in understanding the material presented. The section on surgery has been completely rewritten.

A 40 Year Campaign Against Tuberculosis. By Louis I. Dublin, Ph.D. Pp. 115. New York, Metropolitan Life Insurance Company, 1952.

This monograph records the contribution made by a business organization to the solution of an important medical and social problem.

The book details the various phases of this company's participation and noteworthy achievements in the fight on tuberculosis in which it cooperated with many official and voluntary agencies. Furthermore, it points to even greater possibilities in the future for the joint action of business, government and philanthropy for the public welfare.

BALLAST POINT MANOR

Care of Mild Mental Cases, Senile Disorders
and Invalids
Alcoholics Treated

Aged adjudged cases will be accepted on either permanent or temporary basis.

ACCREDITED HOSPITAL FOR NEUROLOGICAL PATIENTS by
American Medical Assn.
American Hospital Assn.
Florida Hospital Assn.

5226 Nichol St.
Telephone 62-2332

DON SAVAGE
Owner and Manager

P. O. Box 10368
Tampa 9, Florida

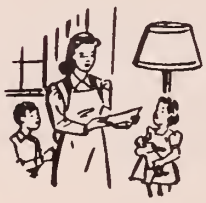
The Right to *Choose* . . . .

CORNERSTONE OF AMERICAN LIBERTY

Hospital Expense Plans

Medical-Surgical Expense Plans

Paycheck Protection Plans



Life Insurance Plan

AS long as Americans keep the right to choose — their church, their political party, their doctor and their hospital — freedom must prevail.

We are proud that hundreds of thousands of Americans have freely chosen the protection afforded them by PENNSYLVANIA LIFE'S liberal, low-cost health insurance plan.

Pennsylvania Life
HEALTH & ACCIDENT **Insurance Company**

FOUNDED 1890

HOME OFFICE: PHILADELPHIA 5, PA.

19 District Offices in Florida

Miami	Executive Office	3028 Biscayne Blvd.	
	Downtown	1210 Pacific Building	
	Southwest	1260 S. W. 22nd Street	
	Little River	8340 N.E. Second Ave., Suite 245	
	Coral Gables	3028 Biscayne Blvd.	
	Miami Beach	206 Harvey Building	
St. Petersburg		509 White Building	
Lakeland		206 Marble Arcade	
West Palm Beach		305 Citizens Building	
Orlando		209 Slayton Building	
Fort Lauderdale		521½ South Andrew Avenue	
Jacksonville		303 Clark Building	
Tampa		228 Cass Street Arcade Building	
Sarasota		237 Main Street, Room 15	
Fort Pierce		Florida Bank Building, Room 34	
Daytona Beach		116½ Orange Avenue	
Tallahassee		429 Centennial Building	
Panama City		142 Harrison Avenue	
Pensacola		501 Theisen Building	

HIGHLAND HOSPITAL, INC.

FOUNDED IN 1904

Asheville, North Carolina

AFFILIATED WITH DUKE UNIVERSITY

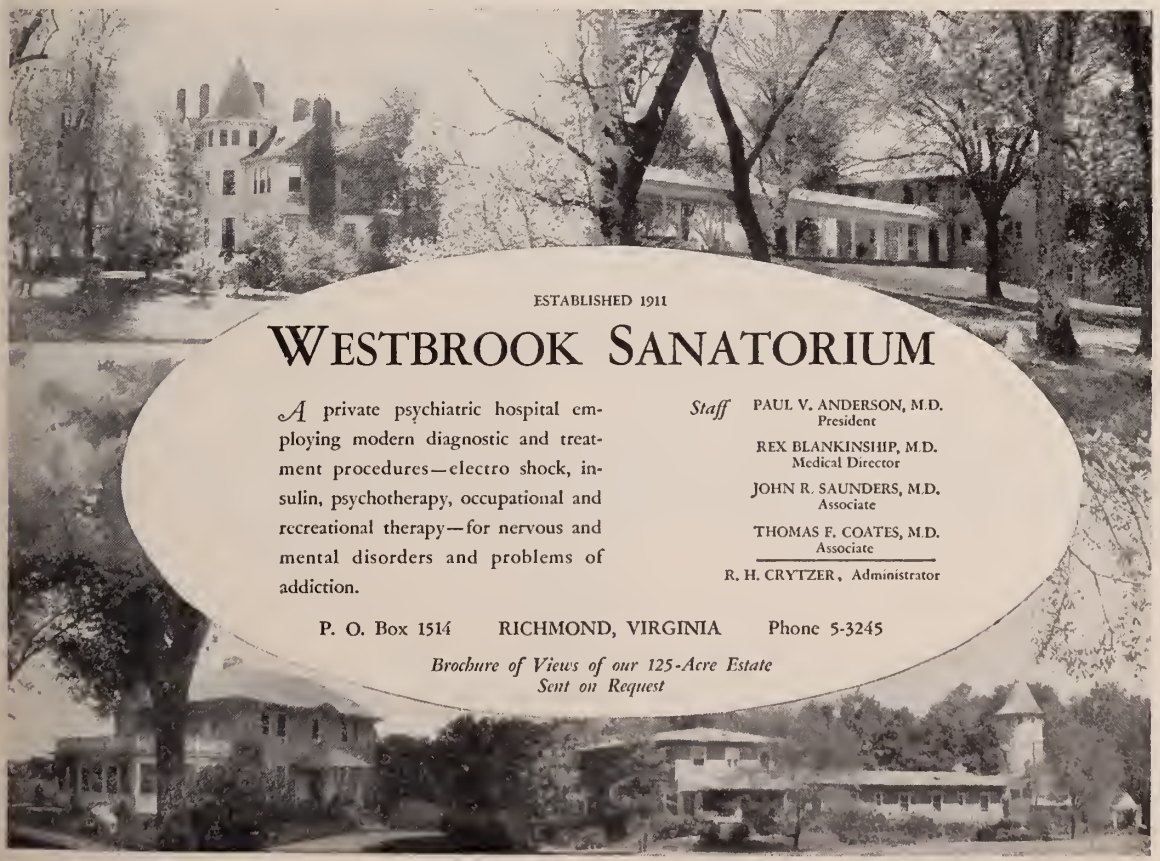
A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a sixty-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D.,
Diplomate in Psychiatry
Medical Director

ROBT. L. CRAIG, M.D.,
Diplomate in Neurology and Psychiatry
Associate Director



ESTABLISHED 1911

WESTBROOK SANATORIUM

A private psychiatric hospital employing modern diagnostic and treatment procedures—electro shock, insulin, psychotherapy, occupational and recreational therapy—for nervous and mental disorders and problems of addiction.

Staff
PAUL V. ANDERSON, M.D.
President
REX BLANKINSHIP, M.D.
Medical Director
JOHN R. SAUNDERS, M.D.
Associate
THOMAS F. COATES, M.D.
Associate
R. H. CRYTZER, Administrator

P. O. Box 1514 RICHMOND, VIRGINIA Phone 5-3245

Brochure of Views of our 125-Acre Estate Sent on Request

TUCKER HOSPITAL, INC.

212 West Franklin Street

RICHMOND, VIRGINIA

A private hospital accepting for diagnosis and treatment organic neurological conditions, selected psychiatric and alcoholic cases, metabolic disturbances of an endocrine nature, individuals who are having difficulty with their personality adjustments, and children with behavior problems. Patients with general medical disorders admitted for treatment under our staff of visiting physicians.

Under the Professional Charge of

DR. HOWARD R. MASTERS,
DR. JAMES ASA SHIELD AND ASSOCIATES

HILL CREST SANITARIUM

FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

Thoroughly modern in architecture and construction. Eight departments — affording proper classification of patients. All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

James A. Becton, M.D., Physician-in-charge — James Keene Ward, M.D., Associate Physician

P. O. Box 2896, Woodlawn Station, Birmingham, Alabama — **Phones 9-1151 and 9-1152**

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Medical Association	Robert B. McIver, Jacksonville	Samuel M. Day, Jacksonville	Hollywood, Apr. 26-29, '53
Medical Districts	Eugene G. Peek, Jr., Ocala	Council Chairman	
rthwest	Francis M. Watson, Marianna	Benjamin A. Wilkinson, Tallahassee	Tallahassee, 1953
rtheast	William C. Thomas, Jr., Gainesville	Eugene L. Jewett, Orlando	St. Augustine, 1953
uthwest	Emmett E. Martin, Haines City	Hugh G. Reaves, Sarasota	Tampa, 1953
utheast	Erasmus B. Hardee, Vero Beach	Donald W. Smith, Miami	West Palm Beach, 1953
Specialty Societies			
y of General Practice	Edward F. Shaver, Tampa	Frank T. Linz, Tampa	Hollywood, Apr. 26, '53
Society	Nelson Zivitz, Miami Beach	Solomon D. Klotz, Orlando	" "
siologists, Soc. of	John T. Stage, Jacksonville	Breckenridge W. Wing, Orlando	" "
r, Am. Coll. Chest Phys.	Alexander Libow, Miami Beach	DeWitt C. Daughtry, Miami	" "
nd Syph., Soc. of	Lewis Capland, Miami Beach	Morris Waisman, Tampa	" "
Officers' Society	George W. Edwards, II, Orlando	Lorenzo L. Parks, Jacksonville	" "
ial & Railway Surgeons	John H. Mitchell, Jacksonville	William H. Chapman, Jacksonville	" "
ogy & Psychiatry	W. Tracy Haverfield, Miami	Roger E. Phillips, Orlando	" "
l Gynec. Society	Dorothy D. Brame, Orlando	J. Champneys Taylor, Jacksonville	" "
l. & Otol., Soc. of	Joseph W. Taylor, Sr., Tampa	Carl S. McLemore, Orlando	" "
edic Society	Arthur H. Weiland, Coral Gables	Edward W. Cullipher, Miami	" "
ogists, Society of	Robert J. Poppiti, Miami Beach	Alfred E. Cronkite, Fort Lauderdale	" "
ic Society	Charlotte C. Maguire, Orlando	Wesley S. Nock, Coral Gables	" "
logic Society	Alex. E. Rosenberg, Miami Bch.	George Williams, Jr., Miami	" "
ogical Society	Thomas H. Lipscomb, Jacksonville	A. Judson Graves, Jacksonville	" "
ical Society	George H. Putnam, Gainesville	David W. Goddard, Daytona Beach	" "
n—			
c Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 6, '53
d Banks, Association	Donald W. Smith, Miami	Mr. J. M. Potts, Miami	Miami, May, 1953
Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 26, '53
er Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
tal Society, State	W. G. McLeod, D.D.S., Pensacola	Coleman Brown, D.D.S., Tampa	St. Petersburg, Apr. 20-23, '53
rt Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
pital Association	Mr. T. F. Little, Daytona Beach	Mr. Tracy B. Hare, Miami	Miami, Nov. '53
ical Examining Board	Ralph B. Spires, DeFuniak Springs	Homer L. Pearson, Jr., Miami	Jacksonville, June 28-30, '53
ical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 22-27, '53
ses Association, State	Mrs. Mary Livingston, W. P. Beach	Mrs. Idalyn Lawthon, Tampa	Tampa, Nov. '53
maceutical Association, State	Mr. Clyde Morris, Daytona Beach	Mr. R. Q. Richards, Ft. Myers	St. Petersburg, May, '53
lic Health Association	Mr. Angus Laird, Tallahassee	Mr. Fred B. Ragland, Jacksonville	Tampa, 1953
erculosis & Health Assn.	Leffie M. Carlton, Jr., Tampa	Mrs. L. C. Conant, Fort Myers	Jacksonville, May 14-15, '53
nan's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	Hollywood, Apr. 26-28, '53
can Medical Association	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	New York, June 1-5, '53
A. Clinical Session	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	St. Louis, Dec. '53
ern Medical Association	Walter C. Jones, Miami	Mr. C. P. Loranz, Birmingham	Atlanta, 1953
na Medical Association	B. W. McNease, Fayette	Douglas L. Cannon, Montgomery	Birmingham, Apr. 16-18, '53
a, Medical Assn. of	C. F. Holton, Savannah	Mr. Sid Wrightsman, Atlanta	Savannah, May 10-13, '53
Hospital Conference	Mr. Norman Losh, Orlando	Mr. D. O. McClusky, Tuscal'sa, Ala.	New Orleans, April 8-10, '53
eastern Allergy Assn.	Clarence Thomas, Nashville, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Havana, Cuba, Mar. 26-29, '53
eastern, Am. Urological Assn.	William Miner, Covington, Ky.	Sidney Smith, Raleigh, N. C.	Nashville, May, '53
eastern Surgical Congress	H. L. Claud, Washington, D. C.	B. T. Beasley, Atlanta	Louisville, Mar. 9-12, '53
Coast Clinical Society	Hays Zieman, Mobile, Ala.	William Atkinson, Mobile, Ala	Mobile, Oct., '53

MIAMI MEDICAL CENTER

P. L. DODGE, M.D.
Medical Director and President

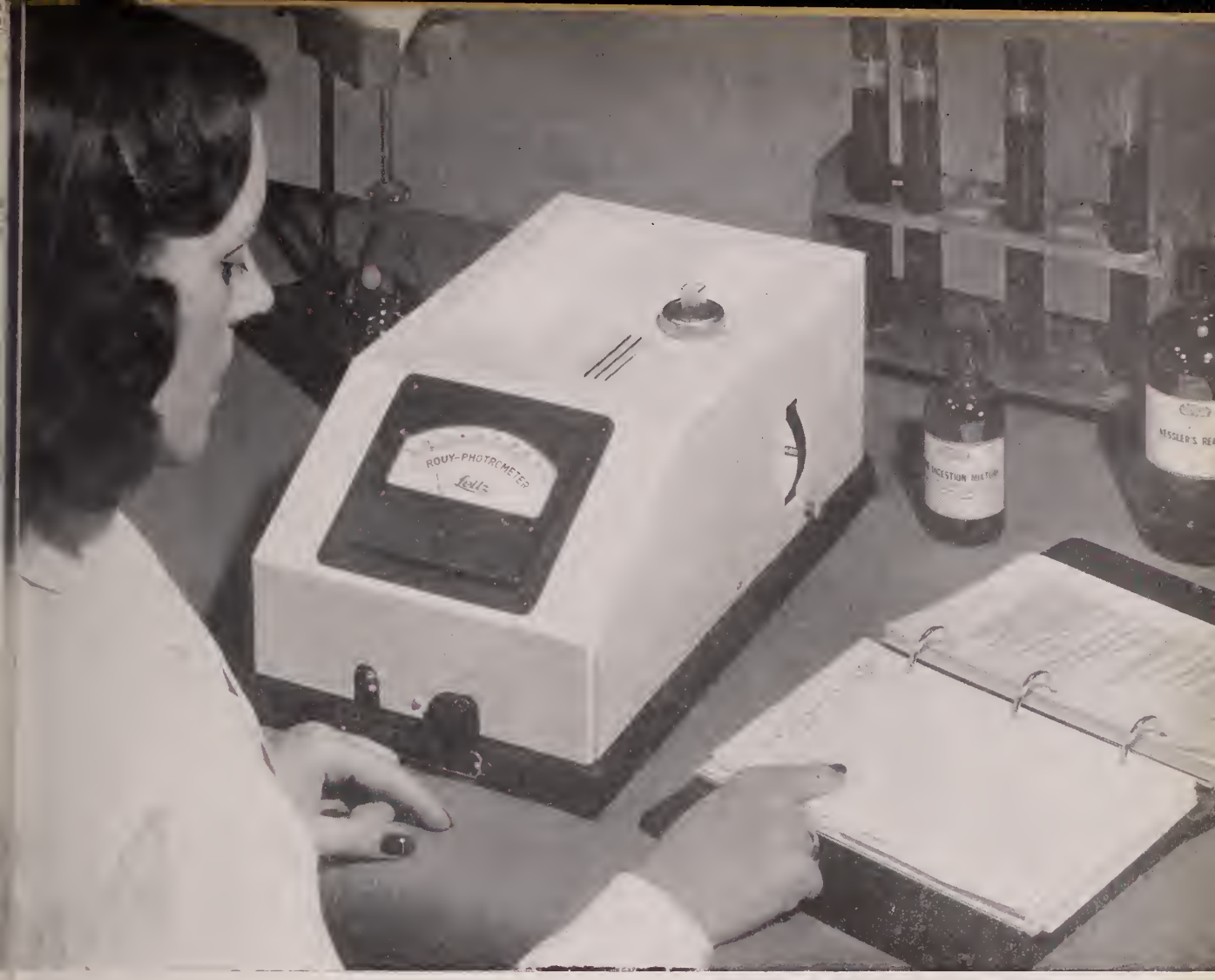
1861 N. W. South River Drive
Phones 2-0243 — 9-1448

A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures — Psychotherapy, Insulin, Electroshock, Hydrotherapy, Diathermy and Physiotherapy when indicated. Adequate facilities for recreation and out-door activities. Cruising and fishing trips on hospital yacht.

Information on request
Member American Hospital Association

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS Hon.	MEMBERS Regular	COUNCILOR
A	Bay	Harold E. Wager, M.D. Box 984 Panama City	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	1st Tuesday 7:30 P.M.	1	23	
	Escambia *Santa Rosa	Alvin L. Stebbins, M.D. 621 N. O St. Pensacola	Paul F. Baranco, M.D. 608 Blount Bldg. Pensacola	2nd Tuesday 8:00 P.M.	0	81	
	Franklin-Gulf			Last Wednesday	0	7	A-1-54 Francis M. Watson, M.D. Marianna
	Jackson-Calhoun	Grayson C. Snyder, M.D. Floyd Bldg. Blountstown	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	1	15	
	Walton-Okaloosa	Edgar H. Myers, M.D. DeFuniak Springs	William D. Cawthon, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	2	14	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		2	3	
B	Columbia *Baker, Hamilton	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	0	14	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	T. Bert Fletcher, Jr., M.D. 516 N. Adams St. Tallahassee	Quarterly 7:30 P.M.	4	55	
	Suwannee	Hiram B. Curry, M.D. Jasper	Edward G. Haskell, Jr., M.D. Branford	1st Saturday 9:30 A.M.	0	8	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		0	3	
	Taylor *Dixie, Lafayette	Mark E. Adams, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	0	3	
	Alachua *Bradford, Gilchrist, Union	F. Emory Bell, M.D. Box 113 Gainesville	Winston L. Summerlin, M.D. 111 S. W. 3rd St. Gainesville	2nd Tuesday 8:00 P.M.	0	47	
	Duval *Clay	W. W. Rogers, M.D. 962 Main St. Jacksonville	John T. Stage, M.D. 2033 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	7	242	
	Marion *Levy	Eugene G. Peek, Jr., M.D. Box 248 Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	1	27	B-3-54 William C. Thomas, Jr., M.D. Gainesville
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	1	10	
	Putnam	Bernard E. Kane, M.D. Box 216 Crescent City	James A. Long, Jr., M.D. 1001 Main St. Palatka	2nd Tuesday 6:00 P.M.	0	9	
	St. Johns	John M. Canakaris, M.D. Box 295 Bunnell	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	0	15	
C	Brevard	Laurent L. LaRoche, M.D. 526 Brevard Ave. Cocoa	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	2nd Tuesday	0	22	
	Lake *Sumter	John D. Bloom, M.D. Groveland	J. Basil Hall, M.D. Tavares	1st Wednesday 7:30 P.M.	1	25	
	Orange *Osceola	G. Tayloe Gwathmey, M.D. 417 E. Robinson Ave. Orlando	Andrew W. Townes, M.D. 717 N. Magnolia Ave. Orlando	3rd Wednesday 8:00 P.M.	6	146	B-4-53 Eugene L. Jewett, M.D. Orlando
	Seminole	Wade H. Garner, M.D. Box 219 Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	0	16	
	Volusia *Flagler	Morris B. Seltzer, M.D. 614 N. Peninsula Dr. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	4	74	
D	Hillsborough	Arthur R. Knauf, M.D. 706 Franklin St. Tampa	Julien C. Pate, Jr., M.D. 1105 First Nat. Bk. Bldg. Tampa	1st Tuesday 8:00 P.M.	3	173	
	Manatee	William D. Sugg, M.D. Bradenton Bank Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	0	17	
	Pasco-Hernando-Citrus	Karl T. Humes, M.D. Box 157 Bushnell	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	1	15	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Pinellas	Everett M. Harrison, M.D. 1601 N. Ft. Harrison Ave. Clearwater	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Mon. Even Mo. 1st Fri. Odd Mo. 6:00 P.M.	13	177	
	Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	Melvin M. Simmons, M.D. 816 Florasota Gardens Sarasota	2nd Tuesday 8:30 P.M.	1	43	
	DeSoto-Hardee-Highlands-Glades	Wesley S. Pyatt, M.D. Bowling Green	Merle C. Kayton, M.D. Wauchula	2nd Tuesday 8:00 P.M.	0	25	
	Lee-Charlotte-Collier-Hendry	Ernest Bostelman, M.D. 201 Pythian Bldg. Fort Myers	Fred D. Bartleson, M.D. 201 Pythian Bldg. Fort Myers	3rd Monday 7:30 P.M.	0	23	C-6-54 Emmett E. Martin, M.D. Haines City
	Polk	Jere W. Annis, M.D. Box 1021 Lakeland	James T. Shelden, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	5	83	
D	Indian River	John P. Gifford, M.D. 1625 Osceola Blvd. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	1	5	
	Palm Beach	Graham W. King, Jr., M.D. Box 505 Delray Beach	David A. Newman, M.D. 175 Bradley Pl. Palm Beach	3rd Monday 8:00 P.M.	1	119	D-7-54 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	John T. McDermid, M.D. 337 N. 4th St. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	1	14	
	Broward	Claus A. Peterson, M.D. 312 Blount Bldg. Ft. Lauderdale	James M. Weaver, M.D. 701 E. Broward Blvd. Ft. Lauderdale	4th Tuesday 8:00 P.M.	4	79	
	Dade	Ralph W. Jack, M.D. 1700 Biscayne Blvd. Miami	Walter W. Sackett, Jr., M.D. 2500 Coral Way Miami	1st Tuesday 8:30 P.M.	24	582	D-8-53 Donald W. Smith, M.D. Miami
	Monroe	Joseph L. G. Lester, Jr., M.D. 422 Fleming St. Key West	Allen S. Shepard, M.D. 638 United St. Key West	2nd Thursday 8:00 P.M.	0	15	
					84	2,229	

*Supervise and aid until organized separately.



THE ROUY-PHOTROMETER by Leitz

Fast **Simple** **Accurate**

Calibrated for 40 Tests	**$257.80**
Calibrated for 22 Tests	**182.80**

MEMBER

AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A. Quality and Service

Anderson Surgical Supply Co.

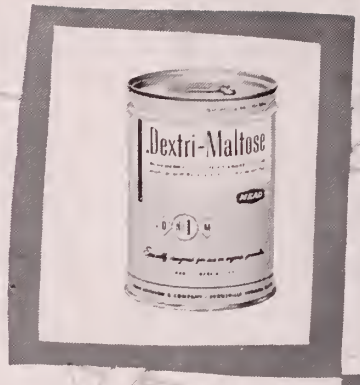
Established 1916

Telephone 5-2560
40-42 W. DUVAL STREET
P. O. Box 1799
JACKSONVILLE, 1, FLORIDA

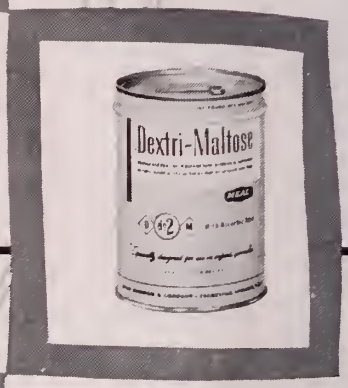
Telephone M-8504
1101-1105 TAMPA STREET
P. O. Box 1228
TAMPA 1, FLORIDA

Telephone 7-4589
21 3rd STREET N.
ST. PETERSBURG, FLORIDA

NEW YORK ACADEMY OF MEDICINE
2 E 103RD ST
NEW YORK N Y 29 J C-E
2



For routine infant feeding. The basic Dextri-Maltose product.



Especially indicated for premature infants. Contains 50 mg. ascorbic acid per ounce.

Dextri-Maltose

MEAD

MEAD JOHNSON & COMPANY
Evansville 21, Ind., U.S.A.

To aid in counteracting constipation. Contains 3% potassium bicarbonate.

designed with singleness of purpose

Designed and manufactured specifically for infant formulas, Dextri-Maltose® has an unequaled background of successful clinical use. Safety for your infant patients is assured by the dry form of this carbohydrate, meticulous laboratory control at all stages in its manufacture, and hermetically sealed, key-opening cans. Dextri-Maltose is palatable but not sweet; does not create a "sweet tooth" in infants. Easily measured without spilling or waste and almost instantly soluble, Dextri-Maltose is convenient for the mother.

Local representative: Roger J. McElroy, 3181 McDonald Street, Coconut Grove 33 Florida, 4-4124.

The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXIX MARCH, 1953 No. 9

CONVENTION AT HOLLYWOOD

MAR 16 1953

IN THIS ISSUE

Peritoneoscopy in Duval County
F. Gordon King

Intralaryngeal Arytenoidectomy
Thomas M. Edwards

Intra-Abdominal Apoplexy
Edwin P. Preston, John W. Snyder and Raymond L. Evans

Parathion Poisoning in Citrus Grove Operations
John W. Williams, J. T. Griffiths, Jr. and C. R. Stearns

Annual Meeting Program — Page 660

OFFICIAL PUBLICATION OF THE
FLORIDA MEDICAL ASSOCIATION

notably effective

well tolerated

broad spectrum antibiotic.

highly effective in a wide range of bacterial, rickettsial, and viral pneumonia CHLOROMYCETIN (chloramphenicol, Parke-Davis) is particularly valuabl in mixed infections and where the causative agent is not easily ascertaine

unusually active against staphylococci CHLOROMYCETIN reduces the lik lihood of bronchopulmonary staphylococcal superinfection, an increasingl common complication.

Chloromycetin®

in the pneumonias

Chloromycetin is rapid in produeing deferveseence and reeovery, aceording to recent eomparative studies.

exceptionally well tolerated, CHLOROMYCETIN is noted for the infrequent oceurrenee of even mild gastrointestinal and other side effeets.

Serious blood disorders following its use are rare. However, it is a potent therapeutie agent, and should not be used indiseriminately or for minor infeetions — and, as with eertain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

Chloromycetin (chloramphenicol, Parke-Davis) is available in a variety of forms, including: Chloromycetin Kapseals,® 250 mg., bottles of 16 and 100. Chloromycetin Capsules, 100 mg., bottles of 25 and 100. Chloromycetin Capsules, 50 mg., bottles of 25 and 100. Chloromycetin Ophthalmic Ointment, 1%, ⅛-ounce collapsible tubes. Chloromycetin Ophthalmic, 25 mg. dry powder for solution, individual vials with droppers.

MEDICAMENTA VERA

Parke, Davis & Company

DETROIT, MICHIGAN

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

Volume XXXIX **MARCH, 1953** **No. 9**

CONTENTS

SCIENTIFIC ARTICLES

Experience with Peritoneoscopy in Duval County, F. Gordon King, M.D. 643
Intralaryngeal Arytenoidectomy in Bilateral Abductor Paralysis of the Vocal Cords, Thomas M. Edwards, M.D. 647
Intra-Abdominal Apoplexy, Report of Case, Edwin P. Preston, M.D., John W. Snyder, M.D., and Raymond L. Evans, M.D. 652
Parathion Poisoning in Citrus Grove Operations in 1951, John W. Williams, M.D., J. T. Griffiths, Jr., Ph.D., and C. R. Stearns, M.D. 655

EDITORIALS AND COMMENTARIES

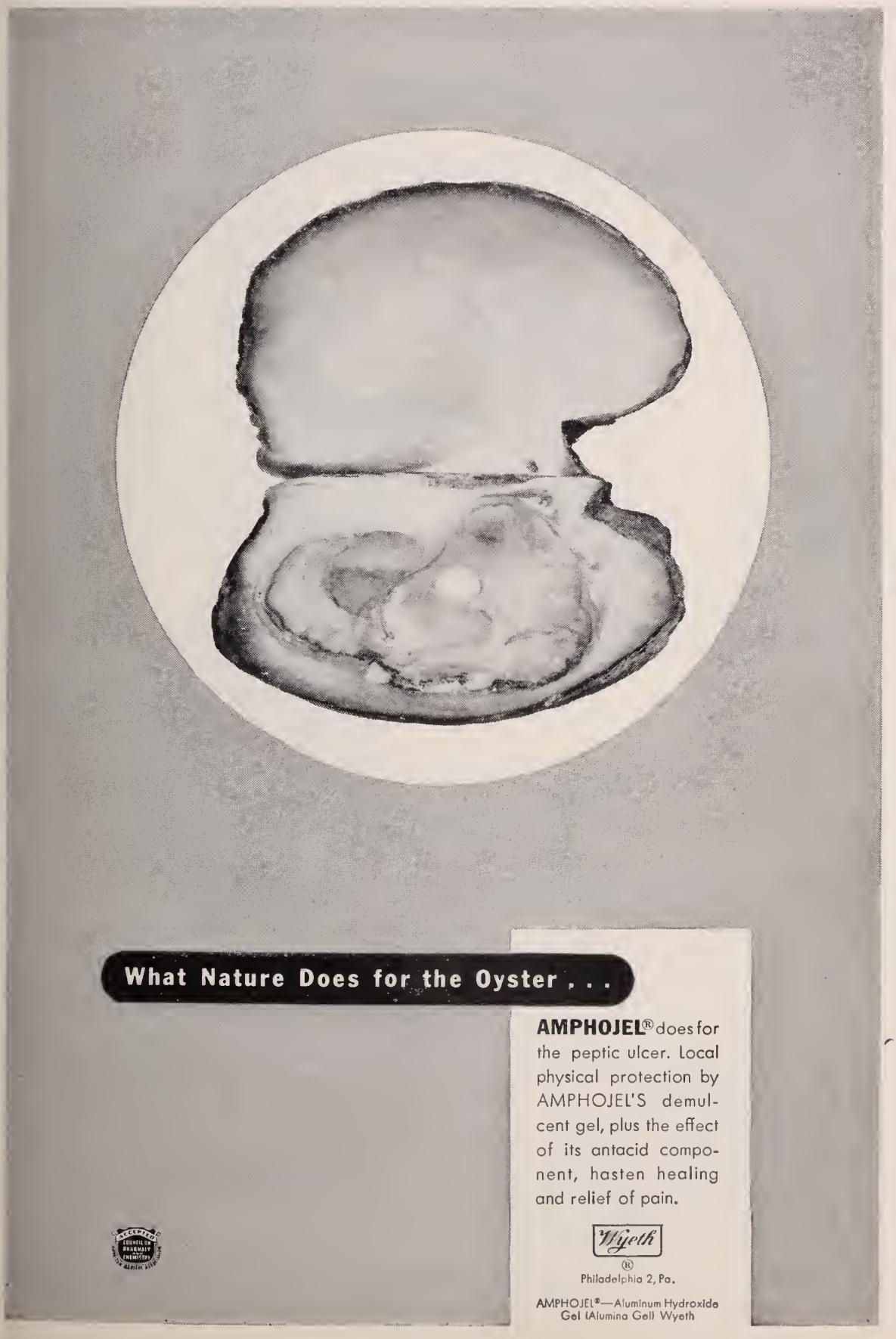
Seventy-Ninth Annual Meeting 674
Notice to Delegates and Committee Chairmen 675
Influenza and Pneumonia 675
Approval for Internships Changed 676
Comparable Hourly Earnings for Physician and Skilled Laborer 676
How Much for Operating Expenses, Doctor? 676
Report of Delegates to A.M.A., Denver, Dec. 2-5, 1952 677
Graduate Medical Education 677
Florida Society of Ophthalmology and Otolaryngology Holds Midwinter Convention 678
Seventh Midwinter Seminar in Ophthalmology and Otolaryngology 678
Florida Cancer Council Annual Meeting Held 679
Revaluation of Tumor Clinics 680

GENERAL FEATURES

Hollywood — Convention City 658
Program of the Seventy-Ninth Annual Meeting 660
Officers and Committees 670
From Our President 672
Frank Howard Lahey, M.D., Guest Speaker 673
Births and Deaths 680
New Members 680
State News Items 681
Medical Officers Returned 683
Wanted — For Sale 683
Component Society Notes 684
Books Received 687
Obituaries 688
Woman's Auxiliary 690
Schedule of Meetings 701
List of County Societies, Presidents and Secretaries 702

This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.


What Nature Does for the Oyster . . .
AMPHOJEL® does for the peptic ulcer. Local physical protection by AMPHOJEL'S demulcent gel, plus the effect of its antacid component, hasten healing and relief of pain.
Wyeth
®
Philadelphia 2, Pa.
AMPHOJEL®—Aluminum Hydroxide Gel (Alumina Gel) Wyeth

STILL the Radiant "First-Nighter"

. . . right through the menopause

on oral estrogen therapy that imparts

No Odor
or
After-Odor,

No Taste
or
After-Taste

CONVINCE her that her next ten years will be as happy and active as the past ten, and you'll answer her secret need for reassurance Put her on SULESTREX, and you'll promptly solve the physical symptoms.

A marked advance in oral estrogenic therapy, SULESTREX is a pure, stable, water-soluble, crystalline compound, deriving its estrogenic activity from estrone. It is *not* a mixture of estrogens, nor does it contain any inactive steroids or uriniferous ingredients.

Reich and associates,[1] in a recent continuing study, observed that SULESTREX "*. . . is a clinically effective oral estrogenic substance, easy to administer and extremely well tolerated . . . with an amazingly low incidence of side reactions.*"

Prescribe it with the assurance that you are using as effective estrogen therapy as science has yet created. Abbott

Sulestrex®

PIPERAZINE
(PIPERAZINE ESTRONE SULFATE, ABBOTT)
Tablets, Sub-U-Tabs® and Elixir

1-131

1. Reich, W. J., et al. (1952), A Recent Advance in Estrogen Therapy. II. American J. Obst. & Gynec., 64-174, July

Truly

broad-spectrum
therapy in
each tasty
teaspoonful

CRYSTALLINE
Terramycin

BRAND OF OXYTETRACYCLINE, AMPHOTERIC

oral suspension

Pure, well-tolerated Terramycin in pleasant raspberry-flavored vehicle.

Each 5 cc. teaspoonful supplies 250 mg. of truly broad-spectrum antibiotic effective against gram-positive and gram-negative bacteria, including the important coli-aerogenes group, rickettsiae, certain large viruses and protozoan organisms.

Don't miss
Pfizer
Spectrum
appearing
regularly in
the J.A.M.A.

Pfizer *world's largest producer of antibiotics*

ANTIBIOTIC DIVISION, CHAS. PFIZER & CO., INC., BROOKLYN 6, N. Y.

Meat...

and the Weight Reduction Diet in Cardiac Disease

The important relationship between obesity and the outlook in cardiac disease and hypertension is vividly emphasized in a recent publication of The American Heart Association.*

For reasons not entirely understood at present, "heart disease and high blood pressure are more common in overweight persons than in those of desirable weight." The predisposition to atherosclerosis in obesity and the increased physical burden of carrying excess weight are undoubtedly contributing factors. Hence, as this publication points out, weight reduction is the first line of defense in decreasing the incidence of cardiac disease, and in improving the prognosis after cardiac disease or hypertension has developed.

Meat occupies a prominent position in the weight reduction diets outlined in this American Heart Association booklet. This recommendation is in sharp contrast to the erroneous belief held in former years that meat is harmful in hypertension or cardiac disease. "There is no evidence that red meat or any other form of protein in moderation has any adverse influence on blood pressure."

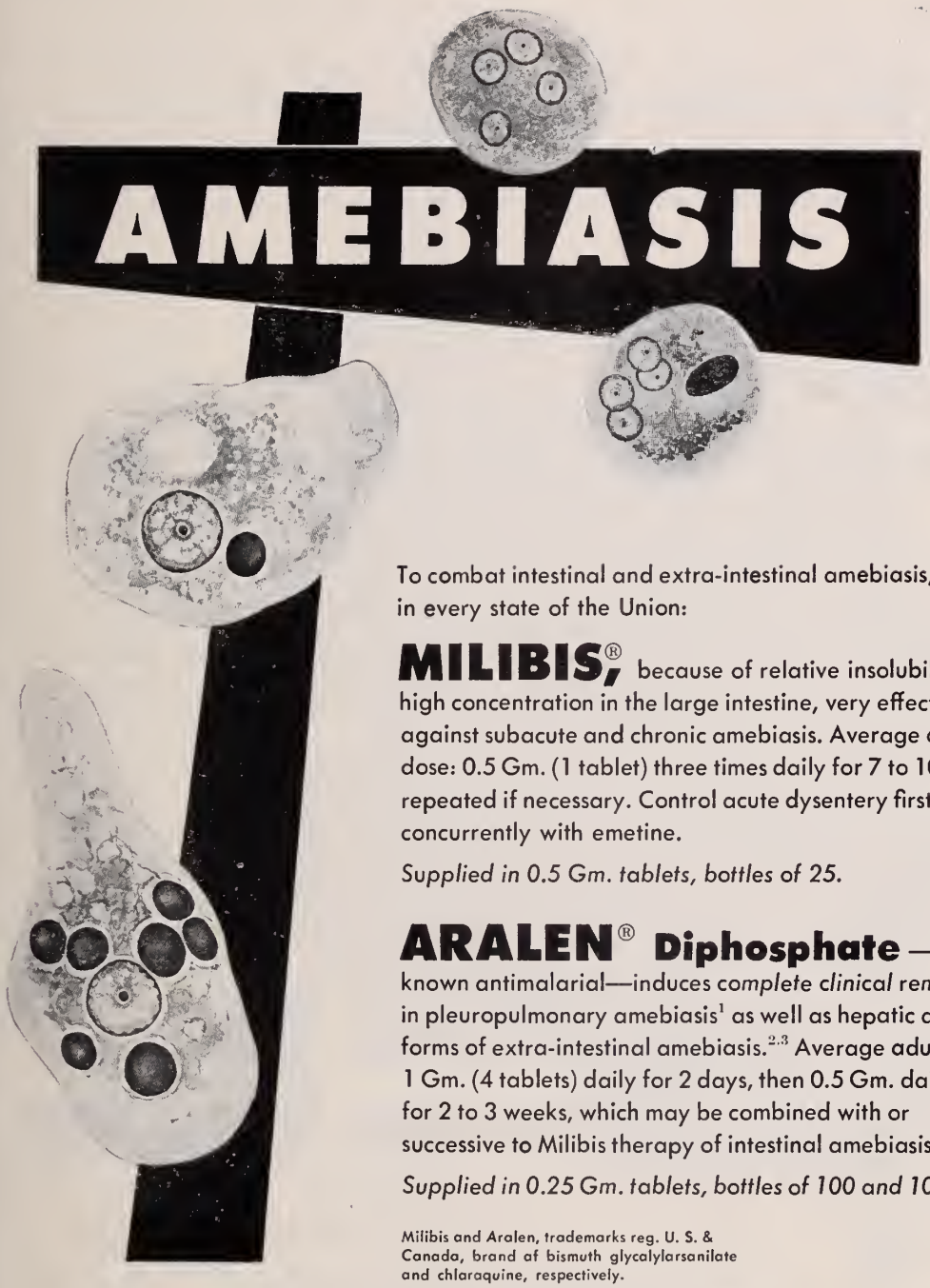
The magic formula for reducing is simply "Eat less." Two types of diets are outlined. One "allows moderate amounts of meat and other proteins, small amounts of fat and moderate amounts of carbohydrates." The other is "high in protein with plenty of meat, eggs and cheese, moderate in fat and low in carbohydrates." Diet No. 1 provides 70 Gm. of protein, 60 Gm. of fat, and 120 Gm. of carbohydrate; caloric yield, 1,300. Diet No. 2 provides 100 Gm. of protein, 80 Gm. of fat, and 60 Gm. of carbohydrate; caloric yield, 1,360.

The inclusion of generous amounts of meat in these diets—12 to 16 ounces of cooked meat or two substantial servings each day in Diet No. 2—is a reflection of the important role meat plays in any weight reduction regimen. It is generously included because of its high content of protein of excellent biologic value and because lean meat contains unobjectionably small amounts of fat.

*Food For Your Heart, a Manual for Patient and Physician, Department of Nutrition, Harvard School of Public Health, Harvard University, The American Heart Association, Inc., New York, 1952. Copies available through local Heart Association.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute
Main Office, Chicago . . . Members Throughout the United States



To combat intestinal and extra-intestinal amebiasis, found in every state of the Union:

MILIBIS,® because of relative insolubility, assures high concentration in the large intestine, very effective against subacute and chronic amebiasis. Average adult dose: 0.5 Gm. (1 tablet) three times daily for 7 to 10 days, repeated if necessary. Control acute dysentery first or concurrently with emetine.

Supplied in 0.5 Gm. tablets, bottles of 25.

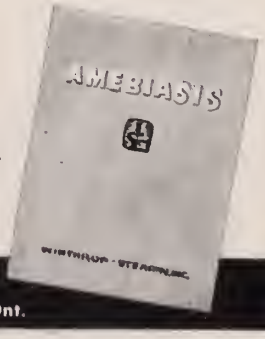
ARALEN® Diphosphate —the well known antimalarial—induces *complete clinical remission* in pleuropulmonary amebiasis[1] as well as hepatic and other forms of extra-intestinal amebiasis.[2,3] Average adult dose: 1 Gm. (4 tablets) daily for 2 days, then 0.5 Gm. daily for 2 to 3 weeks, which may be combined with or successive to Milibis therapy of intestinal amebiasis.

Supplied in 0.25 Gm. tablets, bottles of 100 and 1000.

Milibis and Aralen, trademarks reg. U. S. & Canada, brand of bismuth glycalylarsanilate and chloraquine, respectively.

1. Lindsay, A. E., Gossard, W. H., and Chapman, J. S.: *Dis. Chest*, 20:533, Nov., 1951.
2. Canan, N. J., Jr.: *Am. Jour. Med.*, 6:309, Mar., 1949.
3. Emmett, J.: *J.A.M.A.*, 141:22, Sept. 3, 1949.

Illustrated brochure on request.



WINTHROP-STEARNS INC.
New York 18, N. Y. Windsor, Ont.

The Right to *Choose* . . . .

CORNERSTONE OF AMERICAN LIBERTY

Hospital Expense Plans

Medical-Surgical Expense Plans

Paycheck Protection Plans

Life Insurance Plan

AS long as Americans keep the right to choose — their church, their political party, their doctor and their hospital — freedom must prevail.

We are proud that hundreds of thousands of Americans have freely chosen the protection afforded them by PENNSYLVANIA LIFE'S liberal, low-cost health insurance plan.

Pennsylvania Life
HEALTH & ACCIDENT **Insurance Company**

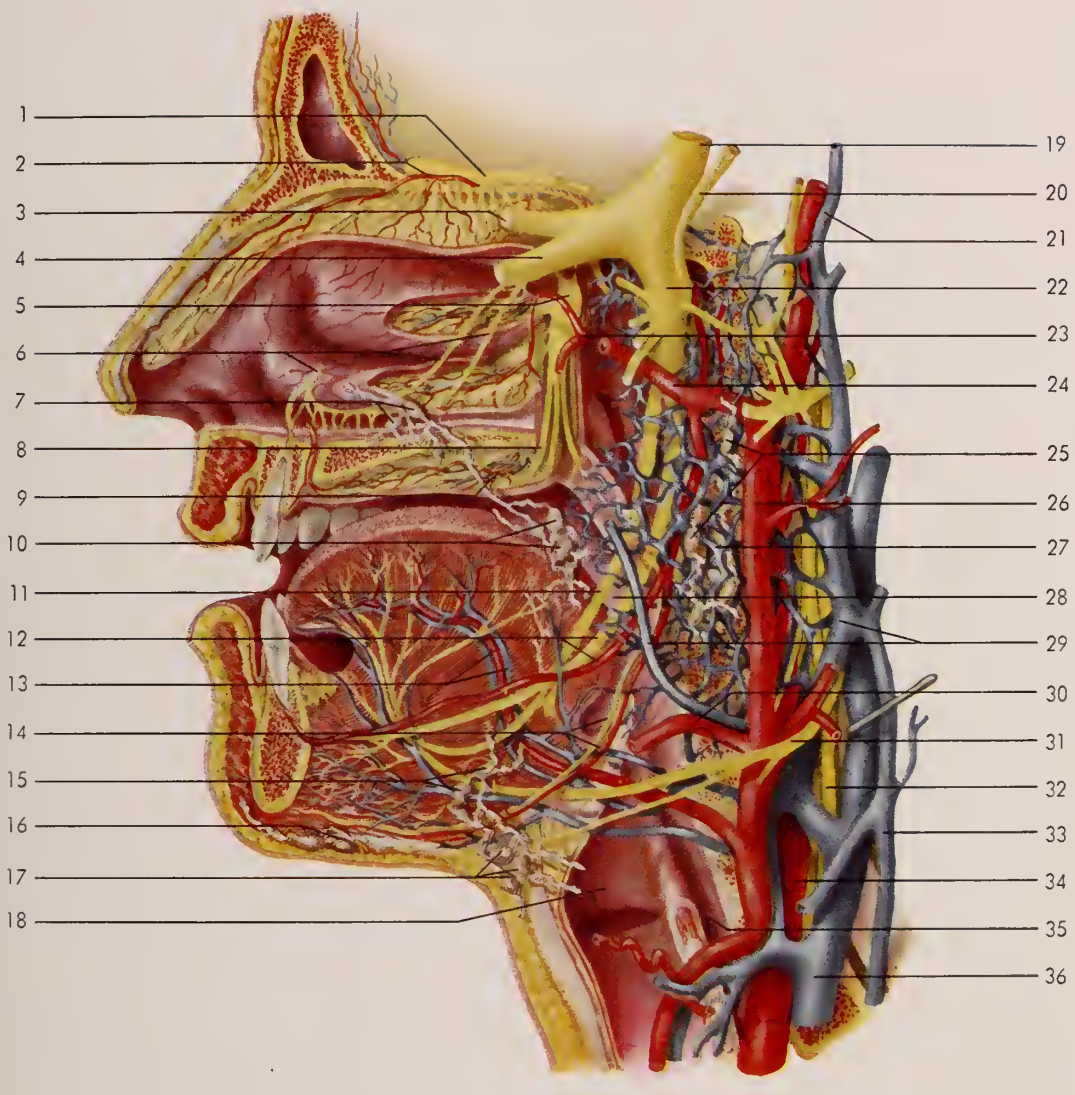
FOUNDED 1890

HOME OFFICE: PHILADELPHIA 5, PA.

19 District Offices in Florida

Miami	Executive Office	3028 Biscayne Blvd.	
	Downtown	1210 Pacific Building	
	Southwest	1260 S. W. 22nd Street	
	Little River	8340 N.E. Second Ave., Suite 245	
	Coral Gables	3028 Biscayne Blvd.	
	Miami Beach	206 Harvey Building	
St. Petersburg		509 White Building	
Lakeland		206 Marble Arcade	
West Palm Beach		305 Citizens Building	
Orlando		209 Slayton Building	
Fort Lauderdale		521½ South Andrew Avenue	
Jacksonville		303 Clark Building	
Tampa		228 Cass Street Arcade Building	
Sarasota		237 Main Street, Room 15	
Fort Pierce		Florida Bank Building, Room 34	
Daytona Beach		116½ Orange Avenue	
Tallahassee		429 Centennial Building	
Panama City		142 Harrison Avenue	
Pensacola		501 Theisen Building	

Anatomy *of the* Mouth



1. Olfactory nerve
2. Anterior ethmoidal artery
3. Ophthalmic nerve
4. Maxillary nerve
5. Sphenopalatine ganglion
6. Anterior, middle & posterior superior alveolar nerves
7. Maxillary lymph nodes
8. Anterior palatine nerve
9. Great palatine artery
10. Buccinator lymph nodes
11. Lingual nerve
12. Inferior alveolar nerve & artery
13. Lingual artery & vein
14. Mylohyoid nerve & artery
15. Supramandibular lymph nodes
16. Submental lymph nodes
17. Submaxillary lymph nodes
18. Trachea
19. Sensory root of trigeminal nerve
20. Motor root of trigeminal nerve
21. Superficial temporal artery & vein
22. Mandibular nerve
23. Sphenopalatine artery
24. Internal maxillary artery
25. Parotid lymph nodes
26. External carotid artery
27. Pterygoid venous plexus
28. Oropharynx
29. Anterior & posterior facial veins
30. External maxillary artery
31. Hypoglossal nerve
32. Vagus nerve
33. External jugular vein
34. Internal carotid artery
35. Esophagus
36. Internal jugular vein

This is one of a series of paintings by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.

Lederle

When infections in the mouth are serious, frequently they will respond to

Aureomycin

HYDROCHLORIDE CRYSTALLINE

Literature available on request

* * *

LEDERLE LABORATORIES DIVISION

AMERICAN Cyanamid COMPANY

30 ROCKEFELLER PLAZA, NEW YORK 20, N.Y.

Upjohn

long-acting
androgen:

Depo-Testosterone

Trademark Reg. U.S. Pat. Off.

CYCLOPENTYLPROPIONATE

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Each cc. contains:

Testosterone Cyclopentylpropionate .....50 mg. or 100 mg.
Chlorobutanol ..... 5 mg.
Cottonseed Oil .....q.s.

50 mg. per cc. available in 10 cc. vials

100 mg. per cc. available in 1 cc. and 10 cc. vials

The Upjohn Company, Kalamazoo, Michigan

"PREMARIN"®

Highly effective • Well tolerated • Imparts a feeling of well-being

"PREMARIN"

Most menopausal patients
experience striking relief
of symptoms with "Premarin."

"PREMARIN"

Estrogenic Substances (water-soluble)

"PREMARIN"

also known as Conjugated Estrogens (equine)

"PREMARIN"

5202 AYERST, McKENNA & HARRISON Limited • New York, N. Y. • Montreal, Canada

SULFA*CETAMIDE*

SULFADIAZINE

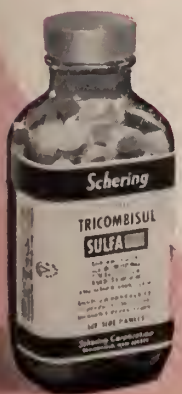
SULFAMERAZINE

the "extra advantage" in this triple sulfonamide is sulfacetamide

TRICOMBISUL® (acet-dia-mer-sulfonamides-Schering) provides not only sulfadiazine and sulfamerazine — standard components of almost all triple sulfonamide mixtures — but also sulfa*cetamide*.

Sulfacetamide brings to the combination extremely high solubility, high bacteriostatic activity, and greater safety for the urinary tract.

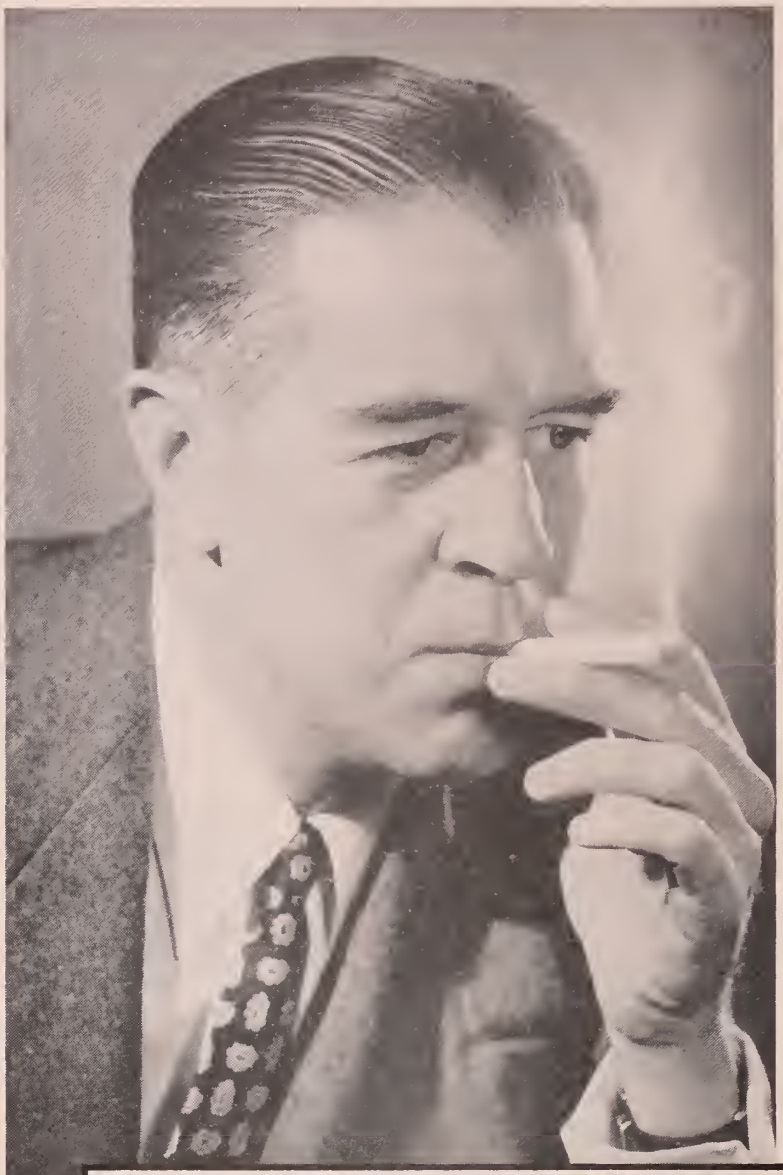
TRICOMBISUL



Schering CORPORATION · BLOOMFIELD, N. J.

TRICOMBISUL

SCHERING



Doctor, be your own judge... try this simple test

With so many claims made in cigarette advertising, you, Doctor, no doubt prefer to judge for yourself. So won't you make this simple test?

Take a PHILIP MORRIS and any other cigarette

1. Light up either one first. Take a puff—get a good mouthful of smoke—and s-l-o-w-l-y let the smoke come *directly* through your nose.

2. Now, do exactly the same thing with the other cigarette.

You will notice a distinct difference between PHILIP MORRIS and any other leading brand.

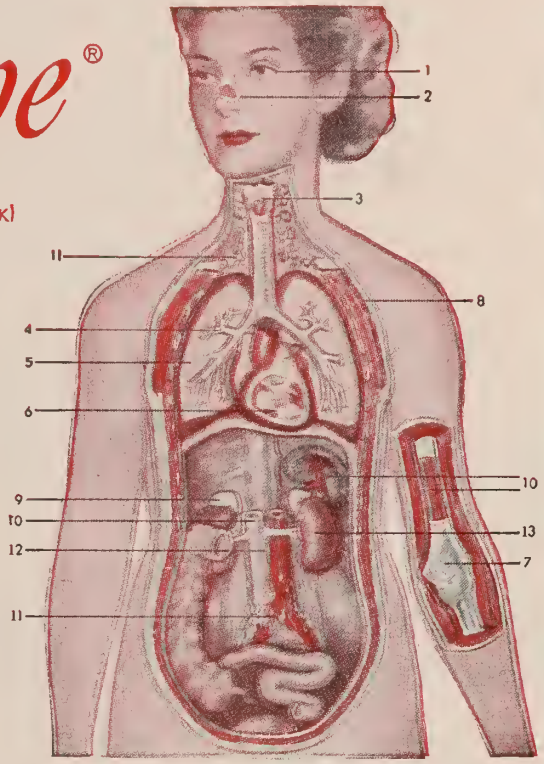
PHILIP MORRIS

Philip Morris & Co. Ltd., Inc., 100 Park Avenue, New York 17, N. Y.

Cortone®

ACETATE

(CORTISONE ACETATE, MERCK)



The many indications for CORTONE *highlight its therapeutic importance in everyday practice*

Primary Site of Pathology and Indications

1. EYE—Inflammatory eye disease. **2. NOSE**—Intractable hay fever. **3. LARYNX**—Laryngeal edema (allergic). **4. BRONCHI**—Intractable bronchial asthma. **5. LUNG**—Sarcoidosis. **6. HEART**—Acute rheumatic fever with carditis. **7. BONES AND JOINTS**—Rheumatoid arthritis; Rheumatoid spondylitis; Acute gouty arthritis; Still's Disease; Psoriatic arthritis. **8. SKIN AND CONNECTIVE TISSUE**—Pemphigus; Exfoliative dermatitis; Atopic dermatitis; Disseminated lupus erythematosus; Scleroderma (early); Dermatomyositis; Poison Ivy. **9. ADRENAL GLAND**—Congenital adrenal hyperplasia; Addison's Disease; Adrenalectomy for hypertension, Cushing's Syndrome, and neoplastic diseases. **10. BLOOD, BONE MARROW, AND SPLEEN**—Allergic purpura; Acute leukemia† (lymphocytic or granulocytic); Chronic lymphatic leukemia.† **11. LYMPH NODES**—Lymphosarcoma†; Hodgkin's Disease†. **12. ARTERIES AND CONNECTIVE TISSUE**—Periarteritis nodosa (early). **13. KIDNEY**—Nephrotic Syndrome, without uremia (to induce withdrawal diuresis). **14. VARIOUS TISSUES**—Sarcoidosis; Angioneurotic edema; Drug sensitization; Serum sickness; Waterhouse-Friderichsen Syndrome.

†Transient beneficial effects.

CORTONE *is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone.*

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY

The Finest
Professional Group

DISABILITY INSURANCE

is written for

COUNTY MEDICAL SOCIETIES

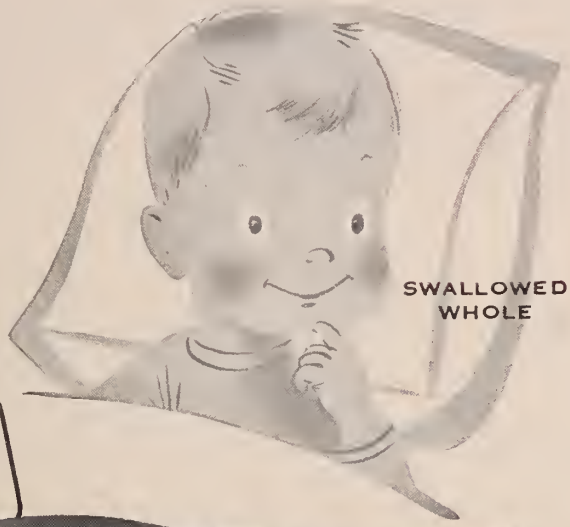
by

EDUCATORS MUTUAL INSURANCE COMPANY

Write today for information for your Society

FRANK GABOR, *President*
GABOR AND COMPANY, INC.
FLORIDA MANAGERS
13th Floor, Pacific Bldg., Miami 32, Fla.
PHONE 9-1483

Local Claim Service Arranged for Every Group



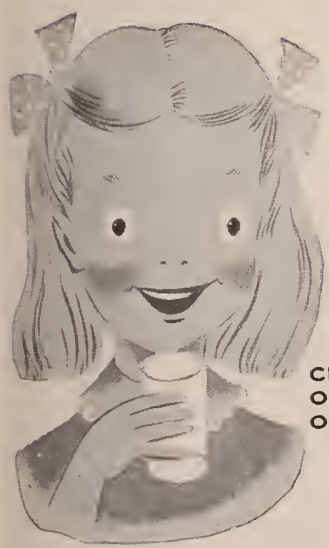
NEW

FLAVORED

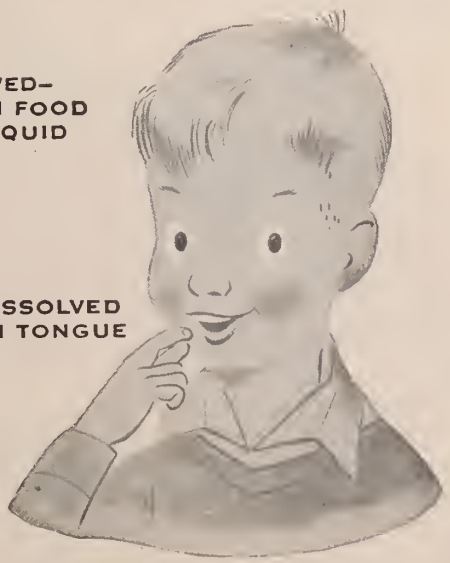
CHILDREN'S SIZE

BAYER

ASPIRIN



CHEWED—
OR IN FOOD
OR LIQUID



DISSOLVED
ON TONGUE

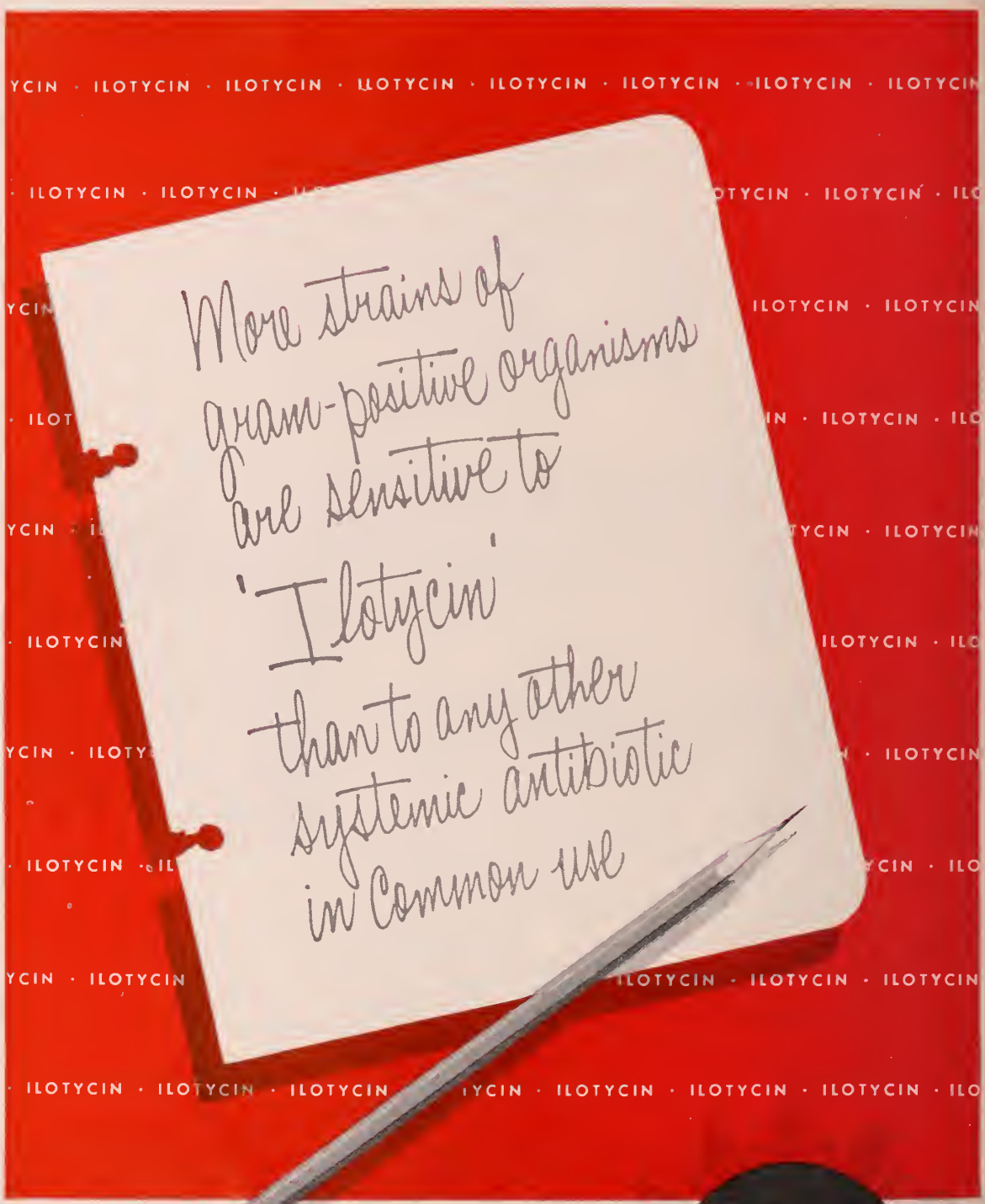
- The Best Tasting Aspirin You Can Prescribe.
- The Flavor Remains Stable Down to the Last Tablet in the Bottle.
- 24 Tablet Bottle . . . 2½ gr. each 15¢

2½ gr. ⇨ 1¼ gr.

Grooved Tablets—
Easily Halved.

We will be pleased to send samples on request

THE BAYER COMPANY DIVISION of Sterling Drug Inc., 1450 Broadway, New York 18, N. Y



AVERAGE DOSE: 2 tablets every four hours.

Supplied in 100-mg. specially coated tablets in bottles of 36.

ILOTYCIN
(ERYTHROMYCIN, LILLY)
CRYSTALLINE

Lilly THE ORIGINATOR OF ERYTHROMYCIN

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXIX | Jacksonville, Florida, March, 1953 | No. 9

Experience With Peritoneoscopy in Duval County

F. Gordon King, M.D.
JACKSONVILLE

In establishing a diagnosis in abdominal disease, occasionally exploratory laparotomy is considered. If there is a probability of palliative or definitive surgical measures, and the patient's general condition allows, such treatment should be advised. If, however, there is a question of satisfactory recovery from exploration, or if the possibility of definitive surgical therapy is slight, much valuable information may be obtained by the use of the peritoneoscope.

The peritoneoscope allows excellent visual examination of the abdominal contents under local anesthesia, through an incision of the skin less than 2 cm. in length. Specimens for biopsy of such size as to be satisfactory to any pathologist can readily be obtained under direct vision. The risk is negligible, hospitalization minimal, and discomfort readily controlled by simple sedation. There is no need to discontinue either the dietary or medical regimen that is in progress. The patient may return home the morning following the procedure. In suitable cases peritoneoscopy is more attractive in many ways than classical exploration.

Description of the Procedure

The procedure is relatively simple. Routine preoperative orders are carried out as for any procedure in which local anesthesia is employed. A light breakfast is allowed the morning of peritoneoscopy. A hypodermic of an opiate and atropine is often desirable an hour before the procedure is carried out.

Preparation of the abdomen from the nipples to the pubis, and well over onto each flank, should be accomplished with standard solutions. Sterile drapes are applied as for major abdominal procedures. A full set of instruments need not be contaminated, nor is it necessary to have a sterile assistant, but facilities for major surgical measures must be quickly available as it may be desirable to proceed with a laparotomy in some instances.

The site for entry is usually below and to the right of the umbilicus, but the site of previous incisions should be avoided. Local anesthetic infiltration of all layers of the abdomen is accomplished, an incision in the skin 1 cm. in length is made, and the fascia is exposed and incised to a length of about 3 mm. Through this incision a long 15 gage needle, fitted with a blunt stylet, is passed through the muscles, fat and peritoneum (fig. 1). Without the side resistance of skin and fascia, it is possible to pass such a needle into the abdomen with relative safety since slight pressure is required. If any unusual resistance is encountered, the needle is passed in a new direction, or it may be withdrawn and passed through an entirely new site.

After the needle is passed into the abdominal cavity, air is pumped in through the needle by means of a sterile manometer bulb. The air lifts the abdominal wall well away from the viscera so that the larger trocar and sheath of the peritoneoscope proper may be passed into the abdomen along the path of the pneumoperitoneum needle. Through the sheath of the trocar various telescopes and biopsy forceps may be introduced and manipulated within the abdominal cavity (fig. 2). Pneumoperitoneum is maintained throughout the procedure to facilitate vision, but minimal air pressure during biopsy is indicated to avoid air embolism, recently reported. To terminate the procedure, the air is removed from the abdomen before removal of the instrument, a single stitch closes the fascial defect, and the skin is closed in

From the surgical services of Duval Medical Center, St. Luke's Hospital, St. Vincent's Hospital, Brewster Hospital and Hope Haven Hospital, Jacksonville.

any standard manner. All previous orders are resumed, and the patient may return home by automobile the following morning.

Fig. 1. — Instruments used in peritoneoscopy. The relative sizes of individual instruments may be surmised by comparison with the 15 cm. (6 inch) ruler in the mid portion of the photograph. A. The pneumoperitoneum cannula and blunt stylet. B. Rubber tubing and a manometer bulb for producing and maintaining pneumoperitoneum. C. The peritoneoscope cannula and trocar. D. Examining telescope and light cord connector. E. Aspirator tube. A flexible aspiration needle for use through the lumen of the scope is shown directly below the aspirator tube. F. The biopsy telescope which operates within the biopsy forceps. G. Various aspirating needles and a Silverman biopsy needle with its split biopsy stylet. H. Electric cord which carries current for lights on the end of telescopes. Insulation of the scope cannula allows fulguration under direct vision with the tip of the biopsy forceps.

Many surgeons have been intrigued by the possibility of examining the abdominal contents by means of a small incision and the readily available cystoscope. The cystoscope is ill-adapted for such use, and attempts to use the instrument in this manner have usually been unsatisfactory and should be discouraged. Since the development of the modern peritoneoscope, examinations may usually be conducted with ease and satisfaction. Even under ideal conditions, however, and with the highly refined peritoneoscope, there are occasions when the surgeon must muster all of his technical knowledge and skill to arrive at a correct diagnosis. Handicapped by improper instruments in such instances, he is placed in a most unhappy situation.

Field of View

The field of view of the peritoneoscope is approximately that which would be obtained if the top of the abdomen were lifted off by an incision along both costal margins, thence down the anterior axillary lines and along Poupart's ligaments to meet again at the symphysis. An incision from the xiphoid process to the symphysis augmented by a transverse incision from one flank to the other would offer no advantages from the standpoint of visual examination alone (fig. 3).

As the telescope enters the abdomen, a field approximately 15 cm. in diameter is obtained. With the scope directed cephalad, the view ordinarily includes the round ligament of the liver as a primary landmark. Much of the inferior margins of the liver, the anterior surface of the liver and the overlying peritoneum of the abdominal wall well upward to the anterior leaves of the diaphragm may be seen in the same view. Directing the scope slightly downward usually brings the fundal portion of the gallbladder, the anterior portion of the stomach, and the anterior transverse colon into view. Directing the scope to the left brings into view much of the fundal portion of the stomach as well as the left transverse and descending portions of the colon which are on the surface. If the spleen is slightly enlarged, it may also be examined. Moving the scope to the right brings the surface of the right anterior portion of the liver and the right half of the colon into view. Thus by moving the telescope's direction, one may examine the entire surface of the abdominal contents in nearly normal size relationship.

If any area does not appear entirely normal, the telescope can be advanced in the direction of that area to give a view in almost any degree of gross magnification desired. One millimeter lesions may be spotted in the manner described and then magnified to fill the entire field with sharp and brilliant detail. Accurately localized specimens for biopsy may be obtained, and the site observed afterward to be certain that bleeding stops. Cauterization of a bleeding area can readily be accomplished, but this has never been necessary in the series here presented.

Some investigators have indicated that it is possible to increase the field of view by rolling the patient from one side to the other, and by raising or lowering the head of the table. Such maneuvers are of dubious value. Digital manipulation through the vagina or rectum while the patient is in the Trendelenburg position may at times extend

the view into the pelvis, but bimanual palpation by experienced fingers is often more informative.

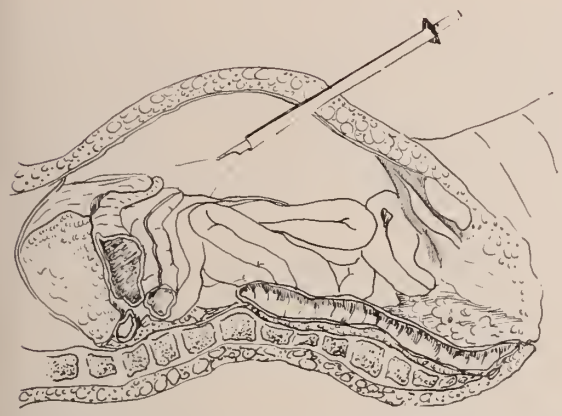


Fig. 2. — By means of pneumoperitoneum the abdominal wall is lifted up from the viscera, allowing excellent visualization of their presenting surfaces.

Value as Diagnostic Procedure

In determining whether peritoneoscopy may be of value in a particular case, one must decide if it is likely that the gross appearance, or biopsies, of the visible liver, intestinal loops, viscera, or peritoneum will establish a diagnosis. It must be realized that exposed viscera cannot be moved and therefore a pathologic condition under the intestinal loops cannot be seen. Lesions which may be seen cannot be palpated, but by pressure through the tip of the instrument it is possible to surmise the consistency of a lesion. This estimate is augmented by the fact that a biopsy forceps in cutting can impart much the same sensation as does the knife when cutting through various tumors.

The procedure is especially reliable for differential diagnosis in cases in which ascites forms. The presence of ascites implies the existence of some variety of hepatic disease, carcinomatosis or tuberculous peritonitis in which the gross pathologic findings are characteristic. The gradual increase in size and number of the neoplastic or tuberculous plaques as the instrument approaches a particular area of the abdominal cavity often indicates this to be the site of primary pathologic change even though it may not be possible to see the lesion. Microscopic studies of biopsy specimens taken here may quickly establish a complete histopathologic diagnosis. Early in my experience, a case of tuberculous peritonitis was mistaken for one of carcinomatosis; the error was quickly corrected by microscopic studies.

Occasionally, the gross appearance is more reliable than microscopic studies of ascites fluid. The cell block studies of ascites in 1 case (E. B.) caused a competent pathologist to report the presence of cells suggesting malignant disease. Later, peritoneoscopy established the presence of advanced cirrhosis as an explanation for the formation of ascites. No evidence of a malignant condition could be found. This latter opinion was accepted with skepticism because of the microscopic studies, but upon institution of a regimen of therapy for cirrhosis, the clinical improvement that followed for a time and the eventual autopsy confirmed the opinion that cirrhosis was the only cause of the ascites.

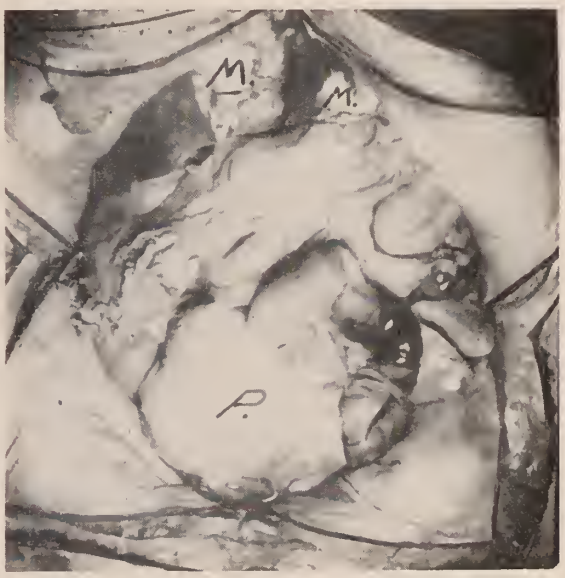


Fig. 3. — A cruciate autopsy incision allows the same view as obtained with the peritoneoscope. Here a pelvic tumor (P.) has metastasized to the liver (M.M.). A laparotomy would give no more information, but cannot be justified since no palliative or definitive surgical measures are possible.

If a tumor which is considered inoperable exists, certain advantages accrue through the excellent specimens for biopsy which may be obtained. At the same time it is often possible to establish whether or not there is local or peritoneal spread of a lesion. In a case of well established obstructive jaundice (A. M.) the lesion was regarded as inoperable because of the poor general stamina of the patient, and because it was believed that the biliary obstruction was due to intrahepatic metastasis from a gastric lesion demonstrated by roentgen studies. Peritoneoscopy showed no evidence of hepatic infiltration; a choledochojejunostomy was immediately performed. Eighteen

months of good palliation was obtained when amelioration of symptoms would have been regarded as hopeless without peritoneoscopy. Such a case is the exception, and ordinarily laparotomy should be the operation of choice when an abdominal tumor is known to exist. Palpation through an adequate incision often decides questions of resectability, and every patient deserves a chance of salvage even though the preoperative chances of surgical help may be slight.

Possible Complications

Perforation of the bowel, hemorrhage and infection are possible but infrequent complications. Conditions preventing normal movement of the abdominal wall away from the viscera as pneumoperitoneum is created may result in visceral perforation. Extreme care must be exercised if adhesions of the bowel to the anterior peritoneum are likely. Distention of the bowel is an absolute contraindication. Fortunately, the perforations that occur are usually extraperitoneal since the causative adhesions also seal the area off from the general peritoneal cavity. When promptly recognized and closed, such perforations cause no difficulty. With ordinary care this is a rare complication, 1 in 200 or less. Following closure of a perforation, another site for entrance is selected, and the procedure is completed. The absence of operative scars may give a false sense of safety, and if tuberculous peritonitis is suspected, extreme caution is indicated. In 2 cases in this series tuberculous adhesion was the cause of extraperitoneal perforation; morbidity, however, was not increased in either instance.

Hemorrhage was not observed in this series, but in no case were specimens for biopsy obtained without a normal prothrombin and bleeding time first having been obtained. Care in selection of sites for procuring biopsy material which are not likely to carry large blood vessels is considered important. Observation of the area after obtaining a specimen will indicate the degree of bleeding and reduce the danger of unrecognized hemorrhage. Cauterization of an area is readily accomplished if bleeding is excessive, but this was not necessary in this series.

This experience involves more than 200 cases encountered over a period of five years in four hospitals in Duval County, but statistical analysis is not warranted since a wealth of similar statistical data concerning the procedure is available for those who may be interested. A short review of several cases may best point out the use and misuse of the procedure:

Report of Cases

Case 1. — A 26 year old Negro woman noticed gradual enlargement of the abdomen. A mass was found in the right side of the pelvis. It was assumed that pelvic malignant disease with peritoneal carcinomatosis was responsible for the ascites elicited on physical examination. Liver function tests indicated damage to the liver, but this could be explained by metastatic infiltration. Because of her age, primary hepatic disease was considered unlikely. A view of the gross appearance and a biopsy of the liver could promptly determine the cause of the ascites. If hepatic disease existed, a laparotomy could offer no chance for definitive surgical measures and would subject the patient to unjustified risk. Peritoneoscopy demonstrated an acute hepatitis and cirrhosis. The pelvic mass was a simple tubo-ovarian abscess.

Case 2. — Malignant cells were reported in the cell block studies of fluid removed from the abdomen of an elderly white woman. It was believed that palliative measures might be carried out if the nature of the primary lesion could be determined. This could not be well established from the sections examined by the pathologist, and her general condition did not allow laparotomy. Peritoneoscopy was carried out, but no evidence of the expected carcinomatosis could be found. There was no evidence to suggest any primary malignant disease; instead, the gross appearance of the liver indicated an advanced cirrhosis. Beautiful compensatory venous shunts between the omentum and the anterior abdominal wall were seen in several areas. The pathologic condition adequately explained the clinical picture. Subsequently, treatment directed at the cirrhosis was carried out, and later a Crosby-Cooney button was placed in the anterior peritoneal wall to aid in control of the ascites. No evidence of malignant disease ever appeared.

Case 3. — In a 45 year old Negro woman, roentgen examination of the chest demonstrated bilateral pleural effusion. She complained of weakness, anorexia and indefinite epigastric pain. The abdomen was enlarged, and the presence of ascites was suspected. Liver function tests indicated some damage to the liver, but laboratory and roentgen studies failed to establish a definite diagnosis. Peritoneoscopy promptly established the presence of multiple tuberculous plaques over the peritoneal surfaces, and microscopic studies of the biopsy material showed typical tubercles and acid-fast organisms.

Case 4. — A 59 year old white man had had a radical resection of the right axilla for a lesion diagnosed as melanotic sarcoma two years previously. The diagnosis was not completely acceptable and could not be confirmed. There had been no evidence of local recurrence, and bone and chest survey roentgen studies for evidence of metastasis had given negative results. For several months he had complained of progressive weakness, and during the past three weeks there had been swelling of the abdomen. There was evidence of ascites on examination. Laboratory studies indicated a pronounced secondary anemia and some hepatic damage. It was desirable to determine whether his present difficulty was due to abdominal carcinomatosis or to intrinsic disease of the liver. Peritoneoscopy readily demonstrated extensive abdominal involvement caused by a grade 4 undifferentiated malignant lesion. The need for specific therapy was eliminated.

Case 5. — A 50 year old white man complained of extreme weakness. Examination revealed a slight cyanosis of the lips, questionable oral and conjunctival petechiae, and a large hematomatous area over the left flank and abdomen. He could recall no bruising injury. Some examiners believed that there was a moderate amount of ascites demonstrable on physical examination. There was questionable enlargement of the liver. All laboratory tests, including capillary fragility and cell fragility, gave normal results. Extensive roentgen studies disclosed no abnormalities.

Peritoneoscopy was carried out in an attempt to establish a diagnosis. An area of subperitoneal hemorrhage corresponding to hematoma of the abdominal wall was visualized, but there was no ascites present, and all visceral and peritoneal surfaces appeared healthy. An extremely thick layer of fat in the abdominal wall, omentum and mesentery stimulated ascites. Biopsies of the liver gave normal results microscopically.

The patient was allowed to return home the day following the procedure and was given a general hygienic regimen to carry out. Periodic examinations over a period of three years have failed to demonstrate any specific disease. He is now in good health, and much less obese. It is believed that peritoneoscopy was of great value since it prevented an unwarranted laparotomy and was reassuring in that possible intra-abdominal disease was ruled out.

Case 6. — In a 60 year old white woman, carcinoma of the pancreatic head causing obstructive jaundice was diagnosed clinically. She repeatedly refused surgical therapy because she was convinced that cancer had spread throughout the abdomen and that operation would simply add to her misery. No one could honestly argue the point with her. After assurance that peritoneoscopic examination gave no evidence of any general spread of the disease, she promptly agreed to enlargement of the incision, and a first stage Whipple resection was carried out.

Case 7. — In a 34 year old white man, roentgen examination of the abdomen gave evidence of pancreatic calculi. He had severe epigastric pain, weakness and great cachexia. He was scheduled to have surgical interruption of the celiac sympathetics, but his appearance and the findings suggested abdominal ascites. This could not be explained adequately on the basis of the known pancreatic disease. Peritoneoscopy revealed extensive hepatic replacement by many soft, almost cystic-appearing masses which, when incised with the biopsy forceps, gave the same sensation as normal liver. The tumor was reported as a primary hepatoma after pathologists had studied the sections. Since the posterior approach to the sympathetics would not have exposed the liver, the true disease would not have been credited with his eventual death. Obviously, the proposed surgical procedure would have subjected the patient to unwarranted discomfort.

Conclusions

Peritoneoscopy is a valuable diagnostic procedure, especially if ascites is present.

The procedure is not a substitute for laparotomy, and it should not be used if there is a reasonable chance of performing definitive surgical therapy.

It is not a "scout" procedure, nor is it a substitute for other established investigative methods.

A definite differential diagnostic problem should exist which can be solved by a view of the gross pathologic condition which may present itself on the undisturbed surface of the abdominal contents or peritoneum. If this is not the case, peritoneoscopy is probably not indicated.

Excellent specimens for biopsy may be readily and accurately obtained.

The cystoscope is not a satisfactory substitute for the peritoneoscope.

Appreciation is expressed to Mary Ann Ballard of Homestead for the medical drawing.

St. James Building.

Intralaryngeal Arytenoidectomy In Bilateral Abductor Paralysis of the Vocal Cords

Thomas M. Edwards, M.D.
TAMPA

Of relatively infrequent occurrence and not well understood by many physicians and surgeons, bilateral recurrent laryngeal paralysis is a deplorable condition which is dangerous if not diagnosed promptly and treated properly. Obstruction of the airway may be increased sufficiently by respiratory infection to cause asphyxiation. Also, if the paralysis is not taken into consideration, the patient may become asphyxiated if subjected to anesthesia. Unilateral abductor paralysis is unfortunate, as Crile[1] remarked a quarter of a century ago, but bilateral abductor paralysis is a tragedy. It is the purpose of this paper to describe the new Thornell surgical approach in the treatment of this condition and also to review 2 cases previously reported[2] and to report a third case in which this procedure was employed successfully.

The muscles which the recurrent laryngeal nerves supply control primarily the three functions of the larynx, namely, air exchange, sound production and defense against the entrance of substances other than gases into the lungs. Paralysis of these nerves, clinically known as bilateral abductor paralysis of the larynx, implies paralysis of all the intrinsic muscles of the larynx, the dilators, constrictors and tensors.

Injury to both recurrent nerves results in immediate loss of voice and of the defensive mechanism. How seriously air exchange is at first affected depends upon the position of the vocal cords immediately after paralysis. Despite a plethora of descriptive terms, there are only three positions for the cord to assume: (1) immediate adduction or midline position, (2) immediate abduction or extreme opening of the paralyzed cord,

and (3) intermediate position about midway between abduction and adduction, known as the cadaveric position. In approximately 90 per cent of all vocal cord paralyses, the cords assume a more or less modified cadaveric position and are in a greatly relaxed or flaccid state. The extent to which the cords and the conus elasticus are sucked into the ring of the cricoid cartilage determines the degree to which the inflowing air current is obstructed.

Incidence

This distressing condition has been reported to be more common in men than in women and rare in children. In a recent series of 66 cases, however, 56 patients were women and 10 were men; the ages ranged from 14 to 76 years, with over half of the patients more than 35 years of age.[3] Some authors noted that abductor paralysis is not uncommon in the newborn, but is frequently overlooked. In one instance, there was recovery in a 2 day old infant with bilateral abductor paralysis requiring tracheotomy.[4]

Etiology

In approximately 90 per cent of the cases of bilateral recurrent laryngeal paralysis peripheral lesions are responsible, with disease of the central nervous system accounting for the remaining 10 per cent. The commonest cause is trauma resulting from thyroidectomy. At operation, the recurrent laryngeal nerves may be incised, pinched, clamped or included in a ligature, or torn loose where they enter the larynx; or hemorrhage, swelling or scar tissue formation may injure them postoperatively. Most frequently there is injury to the trunk of the nerve before its division into anterior and posterior rami, with resulting paralysis of adductors, abductors and constrictors.

Among the numerous other causes mentioned in the literature are syphilis, malignant tumors, arteriosclerosis, pulmonary tuberculosis, arthritis and measles. Disease of the larynx itself is rarely a cause.

Symptoms

Dyspnea and inspiratory stridor, present in varying degree, are the most prominent symptoms in this grave affliction which may result in sudden death by asphyxiation. In some cases, dyspnea and stridor are present more or less all the time; in others, the patient experiences dyspnea only on exertion. These symptoms may become manifest in the operating room; tracheotomy may even be required immediately following the injury to prevent suffocation. In general, however, the obstruction does not require tracheotomy, but is sufficient to cause inspiratory stridor and complete loss of voice except for a whisper, which is not a laryngeal sound. The cords at first are relaxed in the cadaveric position, but are drawn closer together as fibrosis and contractures take place. Pronounced obstructive dyspnea may not develop for a period of six months to a year after the paralysis has occurred. Difficulty in swallowing, especially fluids, may be associated with the initial loss of voice and stridor; improvement in capacity to swallow and temporary improvement in stridor follow.

As the voice gradually returns after a few months, dyspnea develops and is intensified as the voice improves. Stridor accompanies improvement in the voice and becomes so loud during sleep that the patient may become a social outcast.[5] It has been estimated that spontaneous recovery may occur in one fourth of the cases within six months, function rarely returning after that length of time.

Treatment

No known medical treatment will restore function, nor is it possible, as a rule, to remove the cause. For many years the treatment was merely symptomatic or, at most, palliative. It was estimated in 1941 that approximately half of the patients up to that time had been subjected to permanent tracheotomy and the remainder were largely chronic invalids.[5] As an extreme measure to prevent suffocation or to relieve or prevent embarrassing dyspnea, tracheotomy proved more satisfactory than other early methods, and it is often necessary regardless of what other treatment is undertaken.

Surgical therapy has evolved through cordotomy, cordectomy, ventriculocordectomy and anastomosis of the recurrent nerves to the constructive extralaryngeal procedures of King[5] and Kelly,[6] which, with various modifications, have now been employed for a decade.

THORNELL INTRALARYNGEAL APPROACH. — Recently, Thornell[7] conceived an intralaryngeal approach to surgical correction of the condition which has been most favorably received. It is based on the use of the Lynch suspension laryngoscope and consists of complete intralaryngeal arytenoidectomy with lateral fixation of the corresponding vocal cord. In his first cases, 5 per cent cocaine hydrochloride was applied locally over the vocal cord and aryepiglottic fold after the Lynch suspension apparatus was in position. Through the tracheal cannula, a continuous supply

of oxygen was administered during the operation. A 1 cm. incision was made over the superior surface of the arytenoid cartilage and extended anterolaterally into the aryepiglottic fold. The superior border of the cartilage was identified and held tightly by a grasping forceps, preferably with a lock handle.

Submucous dissection of the arytenoid cartilage was then carried out, and a very sharp laryngeal knife was used to separate the various muscular attachments from the cartilage on its lateral aspect. To facilitate the separation of the muscular attachments on the medical aspect of the cartilage, the superior portion of the arytenoid was then rotated laterally. Thornell[7] emphasized that it is extremely important to avoid tearing or injuring the mucous membrane on the lateral wall of the larynx, for scarring in this area with a resulting cicatrix may nullify the attempt to increase the glottic opening.

When complete removal of the arytenoid cartilage has been accomplished, a guarded curved electrocautery point was deeply inserted through the incision along the course of the thyroarytenoid muscle, beneath the vocal cord, and into the space previously occupied by the arytenoid cartilage. By this means further lateral fixation of the posterior two thirds of the vocal cord was obtained through contracture resulting from the electrocautery. Bleeding, which was minimal, was readily controlled with the electrocautery unit.

In the first case Thornell[7] employed a chromic surgical gut suture to close the anterior half of the incision, leaving the posterior portion open for drainage. Thereafter he omitted the suture, but attempted to approximate the edges of the mucous membrane by introducing a gold-plated O'Dwyer intubation tube into the glottis, and later by placing it between the vocal cords, anchoring it inferiorly to the tracheotomy tube and superiorly to the cheek. Eventually he concluded that an acrylic obturator, fashioned to be inserted between the cords and anchored inferiorly to the flange of the tracheal cannula and superiorly to the outer surface of the cheek with adhesive tape, produces closer approximation of the edges of the wound and speeds primary healing. It is removed in from three to seven days. This is the same obturator used by Goodyear[8] in his hemilaryngectomy.

Postoperatively, laryngeal edema was pronounced for the first three or four days, but subsided by the tenth to the fourteenth day. The cannula was removed 20 to 30 days after the operation. From the outset, excellent results were obtained in establishing a normal airway, and there was some improvement in the voice.

Von Leden[9] modified the Thornell procedure by the adaptation of the self-retaining laryngoscope and the use of two additional very sharp dissecting instruments, a straight bistoury and an angular bistoury with double edge blades. Brown[10] also modified the operation. After removing the arytenoid cartilage and accomplishing hemostasis by means of the electrocoagulation current, he placed a mattress suture of 00 chromic catgut so that it entered the lateral aspect of the aryepiglottic fold, passed through the posterior end of the vocal cord, and then passed back through the aryepiglottic fold close to its point of entry. The purpose of this suture was not to close the incision, which was not sutured, but to pull the cord laterally. He omitted insertion of an intubation tube and advised use of an acrylic mold to fit over the front teeth of a patient whose upper front teeth are precarious, made long enough exteriorly to permit it to rest against the anterior nasal spine, to which pressure of the Lynch suspension apparatus is transferred.

In 3 cases I have used the Thornell operation as modified by Brown[10] with gratifying results. Two cases previously reported[2] are here reviewed and the third is reported.

Report of Cases

Case 1.—Mrs. A. L., a white woman aged 52, had been subjected to tracheotomy in Hawaii in 1945 because both recurrent laryngeal nerves were severed during thyroidectomy. She was referred to me by a local surgeon on Jan. 9, 1951. In the interim she had been wearing the tracheotomy tube and was so severely handicapped that she was unemployable and mentally depressed. Both vocal cords were fixed in the midline. Stridor and respiratory difficulty of considerable degree were present when the tracheotomy tube was covered, and the voice was very poor. On May 10, intralaryngeal arytenoidectomy was performed by the Thornell technic as modified by Brown. Intravenous pentothal sodium with curare was used for general anesthesia, and a previously prepared acrylic stent was employed to protect the teeth and jaw.

Laryngeal edema was present for more than a week postoperatively, subsiding rather quickly. Decannulation followed on June 18. The left vocal cord had deviated posteriorly, providing an adequate airway and giving a considerably better voice. On June 26, she was talking much better, was experiencing no stridor, was walking up and down stairs without difficulty and was seeking employment.

Case 2.—Mrs. R. A., a white woman aged 49, complained on Nov. 11, 1950 of severe respiratory difficulty and great stridor experienced since a thyroidectomy four years previously. Her condition was one of semi-invalidism, but she had not been tracheotomized. On May 17, 1951, following tracheotomy under local anesthesia, the patient was anesthetized by intravenous pentothal sodium with curare, and the Thornell operation with the Brown modification was performed. A previously prepared acrylic stent was used to protect the teeth and jaw.

Laryngeal edema persisted postoperatively, but in less than two weeks subsided rather quickly, as in case 1. Decannulation followed on June 13. The right vocal cord had been displaced laterally sufficiently to provide an adequate airway. By August 10 she was pursuing her normal household activities, was walking up and down stairs, and was free of the inspiratory crow during sleep which had greatly disturbed her family.

Case 3.—Mrs. G. D., a white woman aged 57, had been wearing a tracheotomy tube for five years when she was referred to me by a local otolaryngologist in November 1951. Immediate difficulty in breathing had followed thyroidectomy, and the surgeon had been forced to perform a tracheotomy.

The patient was not an ideal subject for intralaryngeal arytenoidectomy because she was obese, the neck was short and thick, and the larynx was small. The operation, however, was planned with the reservation that two stages might be necessary.

The Thornell procedure as modified by Brown was performed on December 5. General anesthesia was induced by intravenous pentothal sodium with curare. A previously prepared acrylic stent was used to protect the teeth and jaw, and the Lynch suspension apparatus was introduced. With the patient in position, the right aryepiglottic fold was injected with a 1 per cent solution of novocain. Incision was made over the length of this fold with a laryngeal knife. The arytenoid cartilage was then seized with a mouse-tooth laryngeal forceps and delivered through the incision without difficulty by means of sharp dissection with laryngeal scissors. After cauterization of the depths of the wound, the gaping mucous membrane was loosely closed with a single suture.

The postoperative course was uneventful. Laryngeal edema of considerable degree lasted for more than a week. On Jan. 4, 1952, one month following the operation, the tracheal cannula was removed. The right vocal cord had been displaced laterally, providing an adequate airway.

The patient has a good voice, almost too good for an adequate airway. She is now able to walk up and down stairs and to work. During sleep, however, there is stridor. It is not believed that a second operation will be necessary.

Comment

The Thornell approach to the surgical therapy of bilateral abductor paralysis of the larynx has been well received. In a recent personal communication, Thornell[11] stated that intralaryngeal arytenoidectomy has now been performed in some 120 cases. He added that he was not using the suture, but regards the acrylic mold employed to approximate the edges of the mucous membrane as the only necessity since adequate space is made available by simple removal of the arytenoid cartilage. He mentioned that neither the suture nor the acrylic mold is at present used at the Mayo Clinic. In his opinion, in cases in which there is a narrow larynx in the anteroposterior direction and in those in which additional space is desired for whatever reason, more thorough electrocauterization lateral to the vocal cord will help to produce this result. As he concluded earlier, his relatively simple procedure "is less time consuming and less shocking to the patient than the various external approaches now advocated."[7]

By his modification of the Thornell procedure Von Leden[9] sought to simplify and increase its popularity, for he was convinced that laryngologists trained in the use of the suspension or the self-retaining laryngoscope will prefer this intralaryngeal approach. He regarded it of particular value in cases in which a previous laryngeal procedure has been performed with subsequent scarring of the laryngeal structures and reported a case of successful intralaryngeal arytenoidectomy which followed on the same side an unsuccessful extralaryngeal operation.

Regarding the new Thornell operation as an approach to an old problem deserving of a thorough trial, Brown[10] emphasized the importance of considering many factors, notably the size and shape of the larynx, the sex of the patient and his psychology. He observed that the result which could be called a success for the person who does sedentary work might be regarded as a failure for a laborer. Likewise, the result that is a success for a person not obliged to use his voice except to make his wants known might be a failure in a clergyman or a teacher. He concluded that should similar results eventuate from the extralaryngeal operation and the intralaryngeal approach, the latter would have ease and simplicity of procedure in its favor.

In the experience of Lynch[2] and his associates, the Thornell operation is successful in patients who do not have to be particularly active physically. They concluded that it is better suited to patients over middle age who lead sedentary lives than to younger more active patients, for whom they prefer the extralaryngeal approach because they think it gives the better airway.

In the 2 cases reviewed here (cases 1 and 2), the Thornell procedure was definitely the operation of choice. In the case reported for the first time (case 3), it would appear that the patient was a borderline selection for this type of surgery. Time alone will reveal whether the intralaryngeal approach or the extralaryngeal procedure emerges as the operation of choice. Certainly intralaryngeal arytenoidectomy recommends itself by its simplicity, but as yet it is not possible to have the best airway with the best voice. It would seem preferable that the patient have as adequate an airway as possible even though he may not be able to talk too well.

As Brown[10] intimated, perhaps patients will be selected on an anatomic basis. For those with a large larynx the intralaryngeal arytenoidectomy may prove more suitable, and for those with a small larynx the extralaryngeal operation may be

preferable. Thornell's suggestion, however, of more thorough electrocauterization lateral to the vocal cord as an aid in obtaining additional space may in large measure obviate choice on an anatomic basis.

Compared with any extralaryngeal approach, the intralaryngeal procedure is not difficult. Nevertheless, it is desirable, prior to performing intralaryngeal arytenoidectomy for the first time, to dissect an arytenoid cartilage from a freshly laryngectomized patient.

In my cases excellent anesthesia and relaxation were obtained by employing a combination of pentothal sodium and curare, supplemented by intratracheal oxygen.

The protective acrylic stent for the teeth and jaw was used in all of my cases and is a necessity in my opinion when the Lynch suspension apparatus is used.

It is estimated that injury to the recurrent laryngeal nerves during thyroidectomy occurs in from 1½ to 3 per cent of cases and is largely an avoidable catastrophe.[12] Since such injury is by far the leading cause of paralysis of these nerves, preventive measures cannot be overemphasized. These are: (1) careful examination of the larynx before thyroid surgery and (2) routine dissection and demonstration of the recurrent laryngeal nerves at the time of surgery. Since unilateral paralysis of the vocal cord is occasionally noted on routine preoperative examination for conditions not related to the thyroid gland, it appears inexpedient to perform thyroidectomy in any case without full knowledge preoperatively of the condition of the vocal cords.

Summary

Intralaryngeal arytenoidectomy as advocated by Thornell[7,11] for the treatment of bilateral abductor paralysis of the vocal cords is described. The incidence, etiology and symptoms of this distressing condition are briefly reviewed.

Two cases previously reported are summarized, and a third case is reported, in all of which the Thornell procedure as modified by Brown[10] was successfully employed.

The intralaryngeal approach is to be recommended for its simplicity and because, as Thornell[7] pointed out, it is less time-consuming and less shocking to the patient than the various external approaches now employed. It may be that the choice between the extralaryngeal and the intralaryngeal operation will come to be based on anatomic considerations, the latter being preferred for patients with a large larynx; or refinements of the intralaryngeal procedure, such as Thornell's recent suggestion of more thorough electrocauterization lateral to the vocal cord in the narrow larynx, may make it preferable in most cases.

As in most instances, the bilateral laryngeal paralysis present in my cases followed thyroidectomy. Precautions widely stressed in the literature are cited which, if observed, would reduce the incidence of this unfortunate sequela.

References

1. Crile, G. W.: The Prevention of Abductor Paralysis in Thyroidectomy, Surg., Gynec. & Obst. 49:538-539 (Oct.) 1929.
2. Edwards, T. M.: Progress in the Surgical Treatment of Bilateral Laryngeal Paralysis, Ann. Otol., Rhin. & Laryng. 61:159-179 (March) 1952.
3. Clerf, L. H.: The Surgical Treatment of Bilateral Posticus Paralysis of the Larynx, Tr. Am. Laryng., Rhin. & Otol. Soc., 1950, pp. 64-74.
4. Pearlman, S. J., and Leshin, N.: Bilateral Abductor Paralysis in a Two Days Old Infant, with Tracheotomy and Recovery, J. A. M. A. 101:1150-1151 (Oct. 7) 1933.
5. King, B. T.: A New and Function-Restoring Operation for Bilateral Abductor Cord Paralysis, Preliminary Report, J. A. M. A. 112:814-823 (March 4) 1939; A New and Function-Restoring Operation for Bilateral Abductor Cord Paralysis, Second Report, J. Internat. Coll. Surgeons 1:223-232 (June) 1941; ——— and Gregg, R. L.: An Anatomical Reason for the Various Behaviors of Paralyzed Vocal Cords, Ann. Otol., Rhin. & Laryng. 57:925-944 (Dec.) 1948.
6. Kelly, J. D.: Surgical Treatment of Bilateral Paralysis of the Abductor Muscles of the Larynx, Tr. Am. Acad. Ophth. 45:133-149, 1940; Surgical Treatment of Bilateral Paralysis of the Abductor Muscles, Arch. Otolaryng. 33:293-304 (Feb.) 1941; A Supplementary Report on Extralaryngeal Arytenoidectomy as a Relief for Bilateral Abductor Muscular Paralysis of the Larynx, Ann. Otol., Rhin. & Laryng. 52:628-636 (Sept.) 1943; Some Problems in the Surgical Treatment of Bilateral Abductor Paralysis of the Larynx, Ann. Otol., Rhin. & Laryng. 53:461-468 (Sept.) 1944; Surgery of the Larynx in Bilateral Abductor Paralysis, J. A. M. A. 134:944-947 (July 12) 1947.
7. Thornell, W. C.: Intralaryngeal Approach for Arytenoidectomy in Bilateral Abductor Paralysis of the Vocal Cords, A Preliminary Report, Arch. Otolaryng. 47:505-508 (April) 1948; Intralaryngeal Approach for Arytenoidectomy in Bilateral Abductor Vocal Cord Paralysis, Tr. Am. Acad. Ophth. 53:631-636 (July) 1949; A New Intralaryngeal Approach in Arytenoidectomy in Bilateral Abductor Paralysis of the Vocal Cords: Report of Three Cases, Arch. Otolaryng. 50:634-639 (Nov.) 1949; A New Intralaryngeal Approach for Arytenoidectomy in the Treatment of Bilateral Abductor Vocal Cord Paralysis, J. Clin. Endocrinol. 10:1118-1125 (Sept.) 1950; Intralaryngeal Arytenoidectomy in the Treatment of Bilateral Abductor Vocal Cord Paralysis, American Academy of Ophthalmology and Otolaryngology, 1950 Instruction Section, Course No. 495; leaflet used at the Scientific Exhibit of the annual meeting of the American Medical Association in June 1951 and at the annual meeting of the American Academy of Ophthalmology and Otolaryngology in October 1951.
8. Goodyear, H. M.: Hemilaryngectomy; Method of Maintaining Satisfactory Airway and Voice, Ann. Otol., Rhin. & Laryng. 58:581-585 (June) 1949.
9. Von Leden, H.: Intralaryngeal Correction of Bilateral Abductor Paralysis: A Modification of the Thornell Operation, Laryngoscope 60:1190-1200 (Dec.) 1950.
10. Brown, L. A.: Intralaryngeal Arytenoidectomy with Observations in Three Cases, Laryngoscope 61:332-340 (April) 1951.
11. Personal communication from Dr. William C. Thornell of Cincinnati, Ohio, dated June 21, 1952.
12. Lahey, F. H., and Hoover, W. B.: Injuries to the Recurrent Laryngeal Nerve in Thyroid Operations, Their Management and Avoidance, Ann. Surg. 108:545-562 (Oct.) 1938.

510 Citizens Building.

Intra-Abdominal Apoplexy Report of Case

EDWIN P. PRESTON, M.D.
JOHN W. SNYDER, M.D.
AND
RAYMOND L. EVANS, M.D.
MIAMI

Intra-abdominal apoplexy may be defined as the spontaneous rupture of a visceral artery with hemorrhage between the leaves of the mesentery, or into the peritoneal cavity. Massive spontaneous intraperitoneal hemorrhage resulting from the nontraumatic rupture of a small intra-abdominal vessel is a rare condition, though the occurrence is being reported with greater frequency. In 1951, 38 cases of this unusual abdominal catastrophe had been reported in the literature.[1,2] An additional case with massive intraperitoneal hemorrhage into the lesser peritoneal sac is herewith reviewed.

Report of Case

The patient, a semirctired white man aged 59, was admitted to Jackson Memorial Hospital on March 11, 1950, with the chief complaint of "swelling of the abdomen for the past week." He stated that he had had a "mild attack of indigestion" following ingestion of a heavy meal one week previously. There was no nausea, vomiting, constipation, or diarrhea, but the abdomen was swollen and uncomfortable. Medication prescribed by one physician gave no relief. Two days later he visited another physician, who hospitalized him, made roentgenograms of the abdomen and chest and advised an exploratory laparotomy, but he refused operation and flew to Miami, where he was again hospitalized. No history of previous abdominal distress could be elicited.

Physical examination revealed a well nourished, well developed white man appearing acutely ill with a temperature of 98.6 F., pulse 100, and respiration 24. The examination other than abdominal, gave grossly negative results. The abdomen was markedly distended and tympanitic. There were no localized areas of tenderness or rigidity and no palpable viseromegaly; no peristalsis was distinctly audible. He got out of bed, voided copiously and also passed gas by rectum. He felt better thereafter.

On roentgen examination, he stood erect for upright films of the abdomen. When he returned to his room, he felt faint, and the blood pressure was 75 mm. systolic and 44 mm. diastolic. The roentgenograms gave no evidence of intestinal obstruction. A blood count revealed 7,400 white blood cells, a fairly normal differential count, but a red blood cell count of 3.3 million with a hemoglobin estimation of 9.5 Gm., or 62 per cent. Urinalysis revealed 3 plus acetone, but otherwise gave negative results. He was transfused with 1,000 cc. of whole blood. Numerous other laboratory procedures were carried out without yielding anything definite regarding the diagnosis (table 1). He would seem to improve for a few days, then get worse. There was a moderately septic temperature course.

Read before the Staff of the Jackson Memorial Hospital, Miami, Feb. 12, 1952.

Table 1. — Laboratory Data

Blood Counts

Date	Hemoglobin Per Cent	Hemoglobin Grams	Red Blood Cells (Millions)	White Blood Cells
3 11 50	62	9.9	3.3	7,400
3 15 50	73	11.24	3.78	7,300
3 19 50	79	12.2	4.65	13,700
3 22 50	68	10.5	3.52	7,400
3 23 50	65	10.01	3.29	.....

3 14 50 Serum amylase 28 mg. per hundred cubic centimeters
3 15 50 Icteric index 15 units
3 16 50 Feces, occult blood negative
Kahn test negative

Urine	Specific Gravity	Albumin	Sugar	Acetone
3 14 50	1.024	Negative	Negative	3 plus

Diagnoses considered were: 1. Hemorrhagic pancreatitis, subacute. 2. Peptic ulcer, perforating into the pancreas. 3. Mesenteric thrombosis with mild involvement. 4. Partial intestinal obstruction of the large bowel.

Flat films of the abdomen gave no evidence of intestinal obstruction, but indicated free fluid might be present in the peritoneal cavity. Fluoroscopy of the upper part of the abdomen failed to reveal fixation of the diaphragm on respiration, but a mass was visible in this portion of the abdomen, pushing the transverse colon downward and the stomach upward (fig. 1). Cystoscopic examination gave negative results, but retrograde pyelograms showed the left kidney displaced downward (fig. 2). The right kidney was in normal position.

We then believed that there was a mass, or collection of fluid in the lesser peritoneal sac, or that a retroperitoneal mass was present. The failure of fixation of the diaphragm was against infection from ruptured ulcer, or pancreatitis. On March 22 the patient had a chill, followed by a temperature of 102.5 F. and he appeared to be losing ground. Operation was advised, and performed by one of us. (RLE). On opening of the abdomen, the lesser peritoneal sac was greatly distended, pushing the colon downward and the stomach upward. Examination of the viscera gave no evidence of infection, perforation or tumor. The mass in the lesser peritoneal sac was tense with indurated and edematous walls. A needle was inserted through the gastrocolic omentum into the mass and old blood withdrawn. The lesser sac was then opened widely, and a large collection of sanguinous fluid and old blood clots was removed. On excavation of the clots there was no fresh bleeding.

Thrombin-soaked gelfoam packs were placed in the large cavity remaining, soft rubber tissue drains were in-

serted, and the incision was closed. Four days postoperatively, the patient had a small pulmonary infarct of the left lower lobe from which he recovered without incident.

The patient continued to improve and was discharged on April 11. He has had no further trouble and has been encouraged to return to an active life. His blood pressure is never over 140 systolic, and the diastolic reading is usually about 80.

Fig. 1.—Mass in the upper part of the abdomen pushing the transverse colon downward and the stomach upward.

Discussion

The precipitating cause of intra-abdominal apoplexy is in most instances hidden and unpredictable. There is a high incidence of hypertension and arteriosclerosis in the cases reported, which suggests that local disease of the blood vessel must be a basic underlying factor. On the other hand, in the postmortem study of 368 cases of generalized arteriosclerosis, Brooks[3] found involvement of the celiac axis in only 9. This number may have some bearing on the relative infrequency of intra-abdominal apoplexy in the presence of generalized hardening of the arteries.

Small aneurysmal dilatations, similar to those observed in the cerebral, the pulmonic and the renal arteries, have been found in the mesenteric arteries. Aneurysmal rupture of a mesenteric dilatation would lead to an easy explanation for the occurrence of massive intraperitoneal hemorrhage in younger persons who are free of known organic disease, but there is no proof that this happens.[1]

The superior mesenteric vessels and the branches of the celiac axis are the site of hemorrhage in the majority of cases. There is a smaller group of cases in which no definite vessel has been identified.[5]

The accident is more frequent in men, in the ratio of 3 men to 1 woman. In the majority of cases the patient is in the sixth decade; the youngest patient observed was 24 years of age, and the oldest was 83 years of age.

Fig. 2.—Retrograde pyelograms showed the left kidney displaced downward. The right kidney was in normal position.

In about two thirds of the cases, rupture of the hematoma or vessel occurs suddenly, and collapse is almost the initial symptom. In the other third, indefinite abdominal pain of variable nature is present prior to the acute accident. In this latter group of cases, the hematoma is confined between the mesenteric leaves or is spreading under the visceral peritoneum. Such extravasations of blood give rise to the characteristic

dull sickening pain of a peritoneum under tension. The pain may subside or diminish and a period of treacherous calm ensue.

The site, amount and persistence of the hemorrhage determine the character of the pain when tension around a hematoma is released by rupture. Excruciating pain is usually experienced, and collapse is determined by the amount of blood lost.

A careful analysis of the signs and symptoms reveals no one finding pathognomonic of the condition. In few instances in the reported cases was a correct diagnosis made prior to operation. Intra-abdominal apoplexy should be suspected in any patient in whom there is sudden severe abdominal pain, shock and signs of peritoneal irritation with evidence of concealed hemorrhage, especially if hypertension and arteriosclerosis coexist. It should be suspected in those cases in which the hematoma is confined between the leaves of the mesentery in the presence of a low hematocrit value.

In the majority of cases a mistaken diagnosis of perforating peptic ulcer, appendicitis with perforation, mesenteric thrombosis, intestinal obstruction, or acute pancreatitis has been made.

Early operation with ligation of the bleeding point, if possible, is the treatment of choice. If a clinical diagnosis can be made in a case in which the bleeding is slow and intermittent, expectant treatment, as advocated by some, seems hazardous.

In 31 (80 per cent) of the 38 cases reported in the literature treatment was surgical and in 9 of these cases the patient died, with a mortality rate of 29 per cent. The diagnosis was made at necropsy in 7 cases in which operation was not performed. In 15 cases the exact anatomic site of the bleeding could not be identified. The prognosis is better in those cases in which a definite bleeding point can be located and the vessels ligated.

In 3 cases resection of the intestine was required, with recovery in 2 cases. In the third case the patient died on the fifth postoperative day of coronary occlusion and myocardial infarction.

In the differential diagnosis, sudden intra-abdominal hemorrhage from the pelvic organs in women, spontaneous rupture of an aneurysm within the abdomen, and massive hemorrhage in connection with a malignant lesion must be considered. Acute intra-abdominal hemorrhage may be associated with acute pancreatitis, and subperitoneal hemorrhage from vitamin C deficiency may simulate an acute abdominal condition.

Conclusion

The concurrence of hypertension, arteriosclerosis and signs of diffuse peritoneal irritation and concealed hemorrhage should arouse strong clinical suspicion of intra-abdominal apoplexy.

Early operation with ligation of the bleeding point, if possible, is the treatment of choice.

References

1. Becker, W. F.: Intra-abdominal Apoplexy, N. Orleans M. & S. J. 104:185-187 (Nov.) 1951.
2. Tanna, J. F.: Abdominal Apoplexy, Am. J. Surg. 73:132-136 (Jan.) 1947.
3. Sharp, W. E., Jr., and Horton, H. S.: Spontaneous Massive Intraperitoneal Hemorrhage with Report of Case, Ann. West. Med. & Surg. 3:322-323 (Sept.) 1949.
4. Berk, J. E.; Rothschild, N. S., and Doane, J. C.: Intra-abdominal Apoplexy, Ann. Surg. 113:513-520 (April) 1941.
5. Marks, M., and Freedlander, S. O.: Spontaneous Intra-abdominal Hemorrhage, Ann. Surg. 121:191-196 (Feb.) 1945.

518 duPont Building.
402 Huntington Building.

The Program of the

Seventy-Ninth Annual Convention

Hollywood Beach Hotel, April 26-29, 1953

Appears on Pages 660-669

Parathion Poisoning in Citrus Grove Operations in 1951

John W. Williams, M.D.
LAKELAND
J. T. Griffiths, Jr., Ph.D.
LAKE ALFRED
AND
C. R. Stearns, M.D.
LAKELAND

Between March 1 and Oct. 31, 1951, 28 cases of supposed parathion poisoning were reported to the Florida Citrus Experiment Station.[1] Of these, 9 were confirmed as parathion poisoning by blood cholinesterase tests, 8 were probably parathion poisoning, and 11 were definitely not parathion poisoning. Of the 9 authenticated cases, in all but 1 there was an exposure period of more than 10 days, the exception being a seven day period. The purpose of this report is to present what is known of the 9 cases among citrus spray labor which were confirmed by blood cholinesterase determinations, to discuss some of the cholinesterase changes which were recorded, and to draw attention to cases in which the use of alcoholic beverages may have complicated the parathion poisoning picture. This paper is a continuation of work previously reported.[2]

Cases 1 through 8 are the 9 confirmed cases in the series of 13 cases. Case 1 is considered as 2 cases since the patient became ill on two different occasions. Case 9 is of considerable interest since the patient had a normal cholinesterase value a week after a critical illness. He became ill after November 1 and his case was not included in the original summary.[1] His clinical symptoms were such that parathion poisoning must be considered to be the proper diagnosis. This case suggests that in order for cholinesterase tests to be valid diagnostic aids, they must be made immediately after the patient becomes ill as in some cases the blood picture returns to normal levels quickly.

In 4 instances blood values were recorded below 65 per cent for red blood cell cholinesterase, and the men continued their exposure to parathion. Within a few days the red blood cell values dropped materially although in only 1 case did the man actually become ill. After five days' additional exposure one man's red blood cell value was reduced from 63 to 25 per cent and another's from 65 to 50 per cent. In a third man, after three days' additional spraying, the red blood cell value was reduced from 50 to 26 per cent. The value in the fourth man showed a change from 61 to 39 per cent after only two days' exposure.

Reductions of comparable size were recorded when red blood cell values were about 75 per cent, but these usually took place over a range of 10 to 15 days. There is the definite implication that once the red blood cell values have reached 65 to 70 per cent, additional parathion exposure may further reduce the cholinesterase out of all proportion to what would happen if the amounts of cholinesterase had been normal.

These data certainly emphasize the extreme importance of regular blood checks during parathion exposure and the necessity for immediately removing a man from additional exposure if the red blood cell cholinesterase values drop below 70 per cent of normal.

Cases 10 through 13 are presented because they suggest the possibility that the use of alcoholic beverages may in some instances complicate parathion poisoning. In case 12 only of these 4 was the patient engaged in a citrus spray operation; in cases 10 and 11 the patients were employed in an insecticide plant; and in case 13 the illness was never positively diagnosed as parathion poisoning. In fact, the death of the patient in this last case was recorded as due to cerebral hemorrhage. Nevertheless, his physician believed at a later date that parathion may well have been

From the Florida Citrus Experiment Station, Lake Alfred.
Pathologist, Morrell Memorial Hospital, Lakeland; formerly associate entomologist, Florida Citrus Experiment Station, at present with Lyons Fertilizer Company, Winter Haven; and Associate Chemist, respectively.

the cause of death. It is our opinion that while the man's previous history showed parathion exposure, it is difficult to believe that illness occurring almost 48 hours after the last parathion exposure could be caused solely by parathion. It is conceivable that when a cholinesterase lowering had been caused by parathion exposure, a liver upset due to the excessive use of alcohol could further complicate the lowering and result in critical illness.

Whether such suggestions are tenable must be determined by experimental investigations. These 4 cases suggest the advisability of reducing the use of alcohol during parathion exposure periods until a complete investigation has been made.

Report of Cases

Case 1.—B. M. was a Negro employed in spraying concentrated parathion. The concentration of parathion was 64 pounds of 15 per cent material per 500 gallons. He drove a Speed Sprayer over which there was no canopy. A blood sample was taken on July 16, four days after he had become ill. At that time the red blood cell cholinesterase value was 48 per cent, the plasma cholinesterase value 41 per cent, and the hemoglobin estimation 87 per cent. He returned to spraying parathion on August 1, in spite of the fact that the red blood cell cholinesterase value on July 30 was still only 69 per cent. He became ill again on August 10 and at that time the red blood cell cholinesterase value had been reduced to 50 per cent, but the plasma value was still at 92 per cent. It is possible that this second instance was not actual parathion poisoning, but positive diagnosis is impossible. In the first sickness on July 12, he suffered from nausea and exhibited only slight muscular weakness. The correct diagnosis at that time was probably mild parathion poisoning.

Case 2.—J. D. was a white man aged 26, employed in spraying parathion. He was applying material at the rate of 2 pounds of 15 per cent material per 100 gallons and had been spraying for a 17 day interval. He was driving a Speed Sprayer part time and during the remainder of the time was handling the supply unit and mixing materials in the tank. He wore a gas mask, rubber gloves and hat, and was supposed to have changed clothes and taken a bath daily. His symptoms on August 17 were nausea, headache, pin-point pupils, muscular weakness, discomfort in the chest and severe sweating. The cholinesterase values at that time were 21 per cent for red blood cells and 3 per cent for plasma. A month later the red blood cell value had returned to 61 per cent and the plasma value to 100 per cent. During the course of spray operations this man had had occasion regularly to remove his gloves and clean out strainers and jets on the sprayer. It is probable that considerable carelessness was involved in this operation. In view of the fact that in the three men with whom he worked the cholinesterase values were considerably reduced (in one instance to red blood cells 74 per cent and plasma 70 per cent; in another to red blood cells 25 per cent and plasma 48 per cent; and in still another to red blood cells 26 per cent and plasma 51 per cent), it would be apparent that all men in the operation were probably not taking the proper precautions. None of the other three men showed symptoms of parathion poisoning.

Case 3.—A. C. T. was a white man employed to spray concentrated parathion. He served both as a Speed Sprayer driver and as a supply tank operator for approximately one month. His blood was first tested on June 18. At that time the red blood cell cholinesterase value was 104 per cent and the plasma value 102 per cent. On July 3, the red blood cell value had dropped to 85 per cent and that of the plasma to 68 per cent, and on July 18 to 61 per cent and 39 per cent, respectively. Unfortunately, at that time his employer was not notified, and he continued to spray. He became ill on July 20, with a red blood cell cholinesterase reading of 32 per cent and a plasma reading of 26 per cent. In this instance the red blood cell cholinesterase dropped rapidly in the course of two days. On July 31, the red blood cell value had returned to 49 per cent and the plasma value to 98 per cent.

Case 4.—J. H. G., a white man, had sprayed parathion steadily for approximately two weeks when he became ill on September 14. At that time he suffered from nausea, pin-point pupils and muscular weakness. The red blood cell cholinesterase value was 23 per cent and the plasma value 32 per cent. He had vomited after work on each of the two days prior to the time he was actually hospitalized. He had served as a mixer of materials and also as a Speed Sprayer driver during his period of exposure.

Case 5.—E. M. was a white man aged 35, who was a Speed Sprayer driver as well as a supply tank operator. He was spraying concentrated parathion at 64 pounds of 15 per cent wettable material per 500 gallons. His initial blood test was made on June 8, when the red blood cell cholinesterase value was 102 per cent and that for the plasma 109 per cent. On July 3, the values had been reduced to 90 per cent and 76 per cent, and on July 13, he reported sick with a cholinesterase value of 48 per cent for red blood cells and 45 per cent for plasma. By July 18, these two levels had risen to 62 and 65 per cent and, on July 31, had attained 73 per cent for red blood cells and 102 per cent for plasma.

Case 6.—L. C. R. was a white man aged 21, who sprayed concentrated parathion with a Speed Sprayer and also served as a supply tank operator. On June 18, he had a red blood cell cholinesterase value of 106 per cent and a plasma value of 132 per cent. On June 25, the values were 100 and 128 per cent. At that time he reported sick, but the blood test did not indicate parathion poisoning. He returned to work on July 3, when the values were 107 and 126 per cent. On July 18, after relatively continuous exposure, they had been reduced to 88 per cent and 68 per cent. On July 28, he became sick, and at that time the values were 42 and 29 per cent for red blood cell and plasma cholinesterase, respectively. By July 31, they had returned to 61 and 64 per cent.

Case 7.—B. L. B. was a white man, who drove a supply tank which supplied a Speed Sprayer. He had been exposed to parathion for 12 days. He was apparently taking normal precautionary measures. At the time of illness he suffered from nausea and headache. Two days after he reported sick the blood test showed cholinesterase values of 65 per cent for red blood cells and 76 per cent for plasma. The initial cholinesterase determinations, made on June 2, had shown 115 and 132 per cent for red blood cells and plasma, respectively, and on June 14, had shown values of 83 and 73 per cent. He became sick six days later on June 20.

Case 8.—N. D. was a Negro 39 years of age, who had sprayed with parathion for seven full days. He was driving a supply truck and mixing parathion. He apparently took normal precautions. He became ill on June 25, and the symptoms were slight headache, nausea, muscular twitching, pin-point pupils, muscular weakness, discomfort in the chest, dizziness and sluggishness. A cholinesterase test showed a red blood cell value of 29 per cent and a plasma value of 17 per cent. On June 28, there was a cholinesterase value of 31 per cent for red blood cells and 37 per cent for plasma. Subsequently, on July 12, the values were 39 per cent and 98 per cent, respectively.

Case 9.—A. M. became ill after he had sprayed with parathion for only three days. Becoming sick after work, he was taken to the hospital, where he passed into a

coma. The pupils were constricted. There was generalized muscular twitching and pronounced pulmonary edema. No nausea was reported or noted by the attending physician. The use of atropine and oxygen resulted in complete recovery. A blood sample at the time of illness was taken in lithium oxalate and not considered valid. It showed a plasma cholinesterase value of 17 per cent and a red blood cell value of 98 per cent. A blood sample considered valid was not obtained until one week after the illness had occurred. At that time the plasma and the red blood cell cholinesterase values were both normal. So far as this test is concerned, one might question the existence of parathion poisoning; however, the report by the physician was clearly indicative that the symptoms were typical of parathion poisoning, and it seems impossible to conclude that he did not have such a condition. Since the pulmonary symptoms were the pronounced ones, this may have been an instance in which acute poisoning by way of the lungs occurred. It may be possible that there was a sudden drop of plasma cholinesterase which was not accompanied by red blood cell drop, and that the patient actually had parathion poisoning without a lowering of the red blood cell cholinesterase levels.

Cases 10 and 11.—S. M. and Y. M. were employed to clean out an oil trap in an insecticide plant. Refuse from drums of technical parathion had been emptied into the pit on occasion. After cleaning the oil trap, these men stopped work at noon, consumed approximately a pint of whisky, and then became sick about the middle of the afternoon. They were taken to a hospital and were treated for parathion poisoning. S. M. was in critical condition and was given a blood transfusion that night. The red blood cell cholinesterase value was 28 per cent and the plasma value 22 per cent. He remained in the hospital eight days and was discharged as completely cured on the ninth day. He had constricted pupils, fibrillary twitching of the muscles, and rigidity of the arm, leg and abdominal muscles. Diarrhea and abdominal cramps continued until the third day in the hospital. He was disoriented on the fourth day and attempted to leave the hospital. He experienced visual and auditory hallucinations. Y. M. had muscular weakness, abdominal pain, and a tight feeling in the chest, but no nausea, vomiting, or diarrhea occurred. He was discharged from the hospital on the seventh day although all symptoms had subsided at the end of 48 hours. The blood cholinesterase values were 42 per cent for red blood cells and 24 per cent for plasma.

Case 12.—G. C. was spraying parathion on Friday, but did not spray on Saturday. On Saturday night he had too much to drink and was taken to the hospital, where a diagnosis of alcoholic colic was made. At the same time a blood test was made, and it was found that the red blood cell cholinesterase value was 109 and the plasma value 45 per cent. Recovery was complete.

Case 13.—I. B. was engaged in spraying vegetables. Apparently he had sprayed parathion off and on for several weeks, but no definite information could be obtained. He stopped spraying on a Friday afternoon. On Saturday night he got drunk. Sunday morning he was taken to a doctor. At that time he had high blood pressure and profuse sweating. His pulse and heart were normal. He thought his legs were paralyzed, but reflexes were normal. Shortly after this examination he went into convulsions and died. There was some fluid in the lungs, but terminal cause of death was not determined. The attending physician thought at a later date that parathion was a major factor to be considered.

Summary

Thirteen cases in which the patients became ill after handling parathion are reported. In 8 of the cases, in which the diagnosis was confirmed by cholinesterase determinations, the patients were engaged in spraying citrus in Florida. Apparently parathion poisoning was the cause of the illness in 1 case, but the cholinesterase value was normal seven days after the patient became ill. The other 4 cases suggest the possibility that the use of alcoholic beverages may complicate parathion poisoning.

References

1. Griffiths, J. T.; Williams, J. W.; Stearns, C. R., and Thompson, W. L.: Health Status of Parathion When Used on Citrus in 1951, Proc. Fla. St. Hort. Soc. 64:79-82, 1951.
2. Williams, J. W., and Griffiths, J. T., Jr.: Parathion Poisoning in Florida Citrus Spray Operations, J. Florida M. A. 37:707-709 (May) 1951.

Drawer 873, Lakeland (Williams).

President's Address

Seventy-Ninth Annual Convention

First House of Delegates Meeting

Hollywood, Tuesday Morning

April 28, 1953

Hollywood -- Convention City

Relax in suburban comfort — revel in big city delights. Those are the lures held out to members, their wives and guests by friendly, gracious Hollywood as she makes ready to play host to the seventy-ninth annual convention of the Florida Medical Association, April 26-29. For the sixth time in two decades, the fourth in succession, tropical Hollywood has given assurance that she will live up to her reputation as one of the finest convention cities.

Hollywood is a seashore city where you can play in the world's greatest resort area, yet relax in tranquil suburban comfort. There are other resorts that by their distance from metropolitan areas afford peace and quiet; and there are those where conventions may be held directly in the center of teeming, big city activity. But in Hollywood, you find the delightful advantages of a small town thriving within the very orbit of one of the most famous recreational regions on earth. Here you have healthful repose, and matchless recreational opportunities free from the milling confusion of a populous city.

Hollywood lies directly on the shores of the Atlantic Ocean, suburban in location to the northern city limits of Miami and Miami Beach. J. W. Young, Hollywood's founder and early developer, laid out her wide palm-lined avenues and waterways with foresight and profound understanding. Here you will find freely moving traffic and ample parking facilities along with pleasant vistas of tropical beauty and thrilling water views. Recreational, cultural, and health advantages, prime aims of Hollywood's plan and development, are today amply provided.

Smart shops of every description, theaters, restaurants and night clubs form the commercial center of the city. Guest accommodations are located on the beach, in town, and in the attractive residential areas. All are conveniently served by quick traffic routes to every point of interest. They range from one of Florida's largest and finest oceanfront hotels to rooms in private homes. In between are luxurious apartments, small hotels and motels.

Cooling Breezes Sweep Sunlit Beach Reserved for Hotel Guests

Hollywood Beach Hotel— Cabanas and Pool, Hotel in Background

Convention headquarters will again be the Hollywood Beach Hotel, which justly deserves its reputation as one of the nation's finest resort hotels. It is one of the few establishments of this type in the state large enough and with adequate facilities to house completely and service a convention of this size. The comfort and convenience of the guests are always prime considerations by the management and staff. The numerous shops within the hotel offer a seemingly endless variety of items.

Ever striving to provide more conveniences and better accommodations, the management has made two changes in the physical plant during the past year which should greatly facilitate the convention activities. A beautiful new wing to the main dining room has been added. This has been designated the Mardi Gras Room and will provide an acoustically designed, air-conditioned, pillar-free room in which to hold general sessions, scientific assemblies and meetings of the House of Delegates. In the arcade on the ground floor an air-conditioned coffee shop, known as the Rendezvous, will provide appetizing meals at popular prices.

Recreational facilities of the hotel and surrounding area include fishing, golf, tennis, handball, shuffleboard, boating, pool or ocean swimming, theaters and six miles of public beach on which to stroll or sun-laze. Fishermen may cast their lines into the rolling surf or the relatively quiet waters of the inland waterway. Regularly scheduled trips and boats for charter are available close at hand for those who prefer to do their angling in deep water. The annual handicap golf tournament for members will be held on the hotel course.

Hotel Golf Course

PROGRAM

of the

Seventy-Ninth Annual Meeting

FLORIDA MEDICAL ASSOCIATION

To be Held at HOLLYWOOD
APRIL 27, 28 and 29, 1953

REGISTRATION

East End of Exhibit Hall

The Registration Desk will be located at the East end of the Exhibit Hall and will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., and Wednesday, 8:30 a.m. to 12:30 p.m. Every member will be required to register and obtain an identification badge before attending any of the sessions. Guests and ladies are required to register at the above designated Registration Desk and obtain their badges.

There is no fee for registration. Printed programs may be obtained at the Registration Desk.

Pay $2.50 for Smoker privileges at the Registration Desk and obtain your receipt tag which is to be shown at the Cabañas and Pool at 9:00 p.m. Monday and worn throughout the evening.

CONVENTION HEADQUARTERS

Hollywood Beach Hotel

The general headquarters will be the Hollywood Beach Hotel, where the registration desk, assembly room for general sessions, meeting place of the House of Delegates, scientific assemblies, information desk and technical exhibit hall will be located.

The Hollywood Beach Hotel will be headquarters Saturday and Sunday for the 17 specialty groups approved by the Board of Governors.

GOLF

The annual handicap golf tournament for members of the Florida Medical Association will be played at the Hollywood Beach Hotel Links. The tournament will be held Sunday, Monday, and Tuesday, April 26, 27, and 28. There will be no green fees for members registered at the Hollywood Beach Hotel. Those registered elsewhere will be charged $1.00 per day. Transportation and lockers furnished free of charge.

Those wishing to participate must be registered and show F. M. A. badges.

Rules: U. S. Golf Association, except local rules.

The entrant must register with the starter before beginning his tournament round. An entrance fee of $1.00 is to be paid to the starter. Score card must be dated, signed, attested and turned in to the starter at the end of the round. The local professional will handicap the players using the Calloway Handicap system.

There will be three awards. The Orlando cup is awarded annually to the low net scorer. Last year's winner was Dr. Willard F. Ande of West Palm Beach. The Duval County Medical Society trophy is awarded to the low gross scorer. Last year's winner was Dr. John D. McKey of Orlando. The Keleket X-Ray award is limited to the radiology division of the tournament. Last year's winner was Dr. E. Hampton Bryson of Coral Gables.

In addition to the three trophies, numerous other prizes will be awarded in this year's tournament.

Those desiring further information are asked to communicate with Dr. Marion W. Hester, Secretary, F. M. A. Golf Committee, 1255 Lakeland Hills Blvd., Lakeland.

ANGLERS

Let's go fishing. Adequate sport fishing boats, guides and other facilities will be available. Appropriate prizes will be awarded for the longest, heaviest and smallest catches.

Interested anglers may secure advance information and reservations by writing to Dr. Thomas C. Kenaston, 501 Delannoy Ave., Cocoa, or directly to either the dockmaster at Hollywood or the dockmaster at Dania.

SMOKER — Stags AND DOES

Monday, 9:00 p.m.

Hollywood Beach Hotel — Cabanas and Pool

Millionaires Party — On the Gold Coast of Florida anything can happen and tonight it is going to. Remember the Carnival? Did you have fun? Well tonight we are going to have more fun and the odds are two bucks, four bits that before the evening is over you'll be a millionaire.

A note to the ladies — Each lady should be accompanied by her husband (if she has a husband), if she has no husband by a gentleman and if she can't find one, just bring a man.

The tariff for the evening's fun is $2.50 per person with smoker receipt tags obtainable at the Registration Desk.

We will see you at the Cabañas at 9:00 p.m. and I'll bet you a million you have fun.

ASSOCIATION DINNER

Tuesday, 7:00 p.m.

Hollywood Beach Hotel — Main Dining Room

Those who are not lodging at the headquarters hotel may obtain dinner tickets ($5.75 per person) from the hotel cashier.

HOTELS

Hollywood Beach — Hotel Headquarters

(American Plan)

Single $18.00 Double $36.00

American Plan rates at the Hollywood Beach Hotel includes meals, which are priced as follows:

Breakfast	$1.75
Luncheon	3.50
Dinner	5.75

Persons not lodging at the headquarters hotel may be served meals in the Main Dining Room at the prices quoted. Individual meal tickets sold at cashier's window will include 10% to cover gratuities for those who do not have rooms in the Headquarters Hotel.

For your convenience we have arranged with the hotel management that there shall be no tipping at any meal. A charge of $1.25 per day will be posted to your hotel account to provide gratuities for dining room employees.

OTHER HOTEL ROOMS

Great Southern (Hollywood Blvd.)	
Single Rooms	$ 3.50- 5.00
Double Rooms	$ 7.00- 8.00
Hutchinson (404 N. 17th Ave.)	
Double Rooms	$ 4.00
Royal Palm (1957 Jackson St.)	
Single Rooms	$ 3.00
Double Rooms	$ 4.00
Sheldon (100 Boardwalk)	
Single Rooms	$ 4.00
Double Rooms	$ 5.00
Surf (300 Boardwalk)	
Single Rooms	$ 7.00
Double Rooms	$11.00
MOTELS	
Bougainvillea (1040 S. Federal)	
Single Rooms	$ 4.00- 5.00
Double Rooms	$ 5.00- 6.00
Apartments (per day)	$ 8.00-12.00
Dillows (1831 Plunkett St.)	
Single Rooms	$ 3.50
Double Rooms	$ 4.00
One bedroom apartments (weekly)	$35.00-40.00
Filson (1753 Jackson St.)	
Single Rooms	$ 4.00
Double Rooms	$ 5.00
Seaside Manor (Ocean Dr. — Mich. St.)	
Single Rooms	$ 4.00
Double Rooms	$ 5.00
Other Rooms (New Section)	$ 7.00- 8.00
APARTMENTS	
Beach and Town (1010 S. Federal)	
Double Rooms	$ 8.50
Efficiency Apartments (daily)	$10.00
Mermaid (319 Pierce St.)	
Efficiency Apartments (daily)	$ 8.00- 9.00

TECHNICAL EXHIBITS

Technical exhibits will be located in the Great Lounge of the Hollywood Beach Hotel. The technical exhibits have a real scientific value, and the physicians who wish to keep abreast of the times and be familiar with the latest development in drugs and medical appliances should spend some time with these exhibits; a surprising amount of useful information can be procured in this way. Many exhibitors make no attempt to sell, the representatives of the firms being there primarily to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

The following firms have arranged for exhibits at the Hollywood meeting:

Booth	Exhibitor
1.	Burroughs-Wellcome & Co., Inc.
2.	Westinghouse Electric Corp., X-Ray Division
3.	Ames Company, Inc.
4.	Lederle Laboratories Division
5.	Tablerock Laboratories
6.	Wm. S. Merrell Company
7.	National Drug Company
8.	Keleket X-Ray of Florida
9.	Chicago Pharmacal Company
10.	C. B. Fleet Company
11.-12.	The Coca-Cola Company
13.	Blairs Braces, Inc.
16.	R. J. Lindquist Co.
17.	Baby Development Clinic
18.	A. H. Robins Company, Inc.
19	Winthrop-Stearns, Inc.
20.	White Laboratories, Inc.
21.	E. R. Squibb & Sons
24.	A. S. Aloe Company
25.-26.	Medical Supply Company
27.	Blair's Associates
28.	Philip Morris & Co., Ltd., Inc.
29.	Mead Johnson & Company
30.	Sandoz Pharmaceuticals
31.	Bilhuber-Knoll Corporation
32.	Eli Lilly and Company
33.	Ayerst, McKenna & Harrison, Ltd.
34.	Ortho Pharmaceutical Corp.
35.	Sherman Laboratories
36.	Mercury Medical Co.
37.	Parke, Davis and Company
38.	Hoffman-LaRoche, Inc.
39.	Chas. Pfizer & Company, Inc.
41.	M & R Laboratories
42.	J. B. Lippincott Company
43.	Carnation Company
44.	Anderson Surgical Supply Co.
45.	General Electric Company, X-Ray Dept.
46.	The Borden Company
47.	Merck & Company, Inc.
48.	Eisele & Company
49.	Executone, Inc.
50.	H. G. Fischer & Co.
51.	Walker Laboratories, Inc.
53.-54.	Southern X-Ray and Supply Co.
55.	The Upjohn Company
56.	Pet Milk Company
57.	Sharp & Dohme, Inc.
58.	Abbott Laboratories
59.	Holland-Rantos Company, Inc.
60.	Ciba Pharmaceutical Products, Inc.
61.	McNeil Laboratories, Inc.
62.	The Nestlé Company, Inc.
63.-64.	Amedic Surgical Company
65.	Schering Corporation
66.	The Medical Protective Company
67.	Ives-Cameron Company, Inc.
68.-69.	Schoetker-Thomas-Koch X-Ray Co.
70	U. S. Vitamin Corp.
71.	The Baker Laboratories, Inc.
72.	J. A. Majors Company
73.	Beech-Nut Packing Company
74.	Wyeth, Inc.
75.	Vanpelt and Brown
76.	Camel Cigarettes
77.	Medco Products Company
78.-79.	The Ritter Company
80.	G. D. Searle and Company
81	Surgical Equipment Company
82.	Parco Surgical Supplies

Doctor: Will you visit each booth and show your appreciation of the exhibitor's fine cooperation and costly outlay?

SCIENTIFIC EXHIBITS

The scientific exhibits will be located in the Arcade on the ground floor of the headquarters hotel. We consider ourselves fortunate to be able to present for your approval the following exhibits:

201. Bronchogenic Carcinoma, Walter R. Newbern, M.D., West Palm Beach.
202. What is Your Heart I Q?, George F. Schmitt, Jr., M.D., Miami.
203. The Renal Arterial Pattern in Man and Animal, Parke G. Smith, M.D., and Jack A. McKenzie, M.D., Miami.
205. Radical Cure of Direct Inguinal Hernias and Bone Transplant, S. L. Governale, M.D., Chicago.
206. Cancer of the Breast and Cancer of the Colon and Rectum, American Cancer Society, Florida Division, Ashbel C. Williams, M.D., Jacksonville.
208. Dade County Cancer Institute, J. Ernest Ayre, M.D., Miami.
209. Etiology of Malpractice, American Medical Association, George B. Larson, Chicago.
210. Early Skin Cancer, Wesley W. Wilson, M.D., Tampa.
212. Continuous Enteral Alimentation, Medical Research Foundation of Dade County, James J. Griffitts, Jr., M.D., and Donald W. Smith, M.D., Miami.
214. Nerve Block Therapy in Painful Syndromes, Harold Carron, M.D., Tampa.
216. Diseases of the Esophagus, Nathaniel M. Levin, M.D., Miami.
218. Lesions of the Cervical Spine, Richard E. Strain, M.D., and Irwin Perlmutter, M.D., Miami.
219. Definitive and Differential Diagnosis of Poliomyelitis, The National Foundation for Infantile Paralysis, New York, Hart E. Van Riper, M.D.
223. Blue Shield of Florida, Leigh F. Robinson, M.D., President, Fort Lauderdale.
225. Public Relations, Florida Medical Association, Eugene B. Maxwell, M.D., Tampa.
226. County Medical Society Displays
227. Woman's Auxiliary to the Florida Medical Association, Mrs. Herschel G. Cole, President, Tampa.

CONVENTION COMMITTEES

Smoker

Russell B. Carson, *Chairman*
David R. Murphey, Jr., *Co-Chairman*

E. Frank McCall — Raymond B. Squires
Whitman C. McConnell — William M. Howdon
Norman E. Williams

Golf

James T. Shelden, *Chairman*
Marion W. Hester, *Secretary*

J. Brown Farrior — J. Maxey Dell, Jr.
Dodge D. Mentzer

Anglers

Thomas C. Kenaston, *Chairman*

Edgar W. Stephens, Jr. — Gerard E. Christie
Councill C. Rudolph — Louis R. Bowen

Greeters

Jack A. McKenzie, *Chairman*

Taylor W. Griffin — Albert L. Ward
O. E. Harrell — Alvin L. Mills
James D. Moffett, Jr. — Leldon W. Martin
Benjamin F. Dickens

Woman's Auxiliary Advisory

C. Robert DeArmas, *Chairman*

Association Dinner

Samuel M. Day, *Chairman*

Robert B. McIver — Frederick K. Herpel

ALUMNI AND FRATERNITY SUPPERS

Monday, 7:00 p.m.

Hollywood Beach Hotel — Dining Rooms

EMORY

7:00 p.m. Supper and program — Sun Room

TULANE

6:30 p.m. Cocktails — Mardi Gras Lounge
7:00 p.m. Supper — Mardi Gras Lounge
8:00 p.m. Address, Dean Maxwell E. Lapham, New Orleans — Mardi Gras Lounge

GEORGIA

7:00 p.m. Supper — Northeast Dining Rooms

FORMER MAYO FELLOWS

7:00 p.m. Supper — Main Dining Room (Northwest Section)

CINCINNATI

7:00 p.m. Supper — Main Dining Room (Southwest Section)

DUKE

7:00 p.m. Supper — Main Dining Room (Southeast Section)

WINNERS OF THE ORLANDO LOVING CUP

The Orlando Loving Cup was donated by the Orange County Medical Society at the Annual Meeting of the Florida Medical Association in 1931 at Orlando.

1931—M. A. Lischkoff, Pensacola
1932—Clarence A. Rudisill, Tampa
1933—Blackburn W. Lowry, Tampa
1934—Hayward J. Blackmon, Tampa
1935—M. A. Lischkoff, Pensacola
1936—Shaler Richardson, Jacksonville
1937—J. R. Chandler, Daytona Beach
1938—William Y. Sayad, West Palm Beach
1939—James T. Cowart, Tampa
1940—Lucien B. Dickerson, Clearwater
1941—William C. Roberts, Panama City
1942—Clarence A. Rudisill, Tampa
1943—No tournament (war)
1944—No tournament (war)
1945—No tournament (war)
1946—Walter C. Jones, Miami
1947—Walter F. Davey, Stuart
1948—Robert D. Harris, Jr., St. Augustine
1949—Dodge D. Mentzer, Lakeland
1950—William G. Meriwether, Plant City
1951—John D. McKey, Orlando
1952—Willard F. Ande, West Palm Beach

WINNERS OF THE DUVAL COUNTY SOCIETY TROPHY

The Duval County Society Trophy was donated by the Duval County Medical Society at the Annual Meeting of the Florida Medical Association in 1952 at Hollywood.

1952—John D. McKey, Orlando

MONDAY

FIRST GENERAL SESSION

Monday, 9:30 to 9:45 a.m.

Hollywood Beach Hotel — Mardi Gras Room

Call to Order, Robert B. McIver, President

Invocation, The Reverend C. C. Frazier, Pastor, Hollywood Methodist Temple, Hollywood

Address of Welcome, V. Marklin Johnson, West Palm Beach

Introduction — Fraternal delegates other states, George R. Dillinger, Thomasville, Ga.; Joyce F. Mixson, Jr., Valdosta, Ga.; J. A. Leaphart, Jesup, Ga.

Announcements

Adjournment

SCIENTIFIC ASSEMBLIES

Committee on Scientific Work: James N. Patterson, Chairman, Tampa; Carol C. Webb, Pensacola; Frederick K. Herpel, West Palm Beach; Jere W. Annis, Lakeland; Richard C. Cumming, Ocala.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the secretary when read."

"No address or paper before the Association, except those of the president and orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject."

FIRST SCIENTIFIC ASSEMBLY

Monday, 9:45 a.m. to 12:30 p.m.

Hollywood Beach Hotel — Mardi Gras Room

9:45 a.m. "Pheochromocytoma" (3¼" x 4" Slides), M. Eugene Flipse, Miami.
Discussion: Walter F. Kvale, Mayo Clinic, Rochester, Minn.

10:15 a.m. "Relationship of Fat Metabolism to Atherosclerosis" (3¼" x 4" Slides), Dale L. Groom, Miami.
Discussion: Virgil Moon, Miami
Robert J. Needles, St. Petersburg

10:45 a.m. "Some Unsolved Problems in Industrial Surgery" (3¼" x 4" Slides), Henry C. Marble, Surgeon-in-Chief, Chelsea Memorial Hospital, Boston.

11:15 a.m. Recess.

11:30 a.m. "Prevention and Treatment of Anesthetic Accidents" (3¼" x 4" Slides), Harold Carron, Tampa.
Discussion: Ralph S. Sappenfield, Miami

12:00 a.m. "Cause and Treatment of Non-union of Tibial Fractures; Indications and Technic for Ankle Fusions" (3¼" x 4" Slides), Guy A. Caldwell, Chief Orthopedic Surgeon, Oschner Clinic, New Orleans.

SECOND SCIENTIFIC ASSEMBLY

Monday, 2:00 to 4:45 p.m.

Hollywood Beach Hotel — Mardi Gras Room

2:00 p.m. "The Treatment of Post-Thrombophlebitic Changes in the Legs by Various Surgical and Conservative Means" (3¼" x 4" Slides), Frederick H. Bowen, Jacksonville.
Discussion: George D. Lilly, Miami
George W. Morse, Pensacola

2:30 p.m. "Hematuria, Its Pathological Significance" (3¼" x 4" Slides), George F. Cahill, New York.

3:00 p.m. "Indications for Surgery in the Treatment of Pulmonary Disease" (3¼" x 4" Slides) Hawley H. Seiler, Tampa.
Discussion: DeWitt C. Daughtry, Miami

3:30 p.m. Recess.

3:45 p.m. "The Surgical Treatment of Cervical and Fundal Malignancies" (3¼" x 4" Slides), Joseph H. Pratt, Mayo Clinic, Assistant Professor of Surgery, University of Minnesota, Minneapolis.

4:15 p.m. "Tracheo-esophageal Fistula with Atresia of the Esophagus," Ashbel C. Williams, Hugh A. Carithers and Nathan Weil, Jr., Jacksonville.

ALUMNI AND FRATERNITY SUPPERS

Monday, 7:00 p.m.

Hollywood Beach Hotel — Dining Rooms

(See page 662)

SMOKER — Stags AND DOES

Monday, 9:00 p.m.

Hollywood Beach Hotel — Cabanas and Pool

Millionaires Party — On the Gold Coast of Florida anything can happen and tonight it is going to. Remember the Carnival? Did you have fun? Well tonight we are going to have more fun and the odds are two bucks, four bits that before the evening is over you'll be a millionaire.

A note to the ladies — Each lady should be accompanied by her husband (if she has a husband), if she has no husband bring a gentleman and if she can't find one, just bring a man.

The tariff for the evening's fun is $2.50 per person with smoker receipt tags obtainable at the Registration Desk.

We will see you at the Cabañas at 9:00 p.m. and I'll bet you a million you have fun.

Scientific and technical exhibitors have arranged elaborate informational displays. Attendants will be on hand at each booth to explain their exhibit and to answer your questions.

TUESDAY

FIRST MEETING HOUSE OF DELEGATES

Tuesday, 9:30 a.m.

HOLLYWOOD BEACH HOTEL — MARDI GRAS ROOM

Delegates assemble at the Credentials Committee table at entrance of the Mardi Gras Room at 9:00 a.m. to present their credentials, fill out attendance cards and receive special badges from the Credentials Committee:

Louis M. Orr, II, Chairman
James L. Borland
Herbert L. Bryans

Delegates are to occupy seats in the front section in order that they may be grouped together. Other members of the Association and guests are requested to occupy seats in the rear section of the room.

9:30 a.m., President McIver in the Chair.

Parliamentarian for the President — Joseph S. Stewart

Number of eligible Delegates present. Report by Louis M. Orr, II, Chairman, Credentials Committee

Motion to seat Delegates if a quorum is present

Adoption of minutes as published in June 1952 Journal

Gavel to First Vice President, Francis H. Langley

President's Address, Robert B. McIver

President Resumes Chair

Election of one Delegate and one Alternate to A.M.A. House of Delegates for two year terms beginning January 1, 1954

(Terms expiring December 31, 1953 — Delegate, Louis M. Orr, II; Alternate, Joshua C. Dickinson)

Letter from Dr. George F. Lull, Secretary, A.M.A., dated January 20, 1953:

(Your constituent association is entitled to (2) delegates in accordance with the apportionment now in effect of one delegate for each 1,000, or fraction thereof, active members.)

June 1951, Florida Medical Journal, page 782:

(The Chair called for the election of a third delegate to A.M.A., the term to be two years or such portion thereof as the Association is entitled to a third delegate. This third delegate will be allowed by the A.M.A. only so long as the paid membership in the A.M.A. equals or exceeds 2,001 members. In the event the membership falls below 2,001, this third delegate is to be dropped.)

Since the third delegate elected failed to qualify for 1951, Dr. Herbert L. Bryans, Alternate, was seated in the A.M.A. House of Delegates.

June 1952 Florida Medical Journal, page 857:

(The Chair ruled it in order to elect a third Delegate to the A.M.A. House of Delegates for the remainder of 1952 and for a two year term beginning Jan. 1, 1953. Dr. Herbert L. Bryans was elected.)

Since the F.M.A. is only entitled to two delegates for 1953, it would appear that the third delegate must remain inactive for that calendar year.

(A. M. A. By-Laws, Chapter IX, Sec. 1: "In order to be eligible for election to membership in the House of Delegates, a physician must have been an Active or Service Member of the American Medical Association for at least two years immediately preceding the session of the House in which he is to serve.")

Reference Committee Personnel announced by President

Presentation of Resolutions *(Resolutions not included in House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the Speaker's table immediately after they are presented.)*

Reports of Committee Chairmen:

(To Reference Committee No. 1)

Scientific Work, James N. Patterson
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Frazier J. Payton
Venereal Disease Control, Melvin M. Simmons
Tuberculosis and Public Health, Ralph S. Sappenfield
Maternal Welfare, E. Frank McCall
Child Health, Luther W. Holloway
Scientific Assembly and Specialty Group Problem, Herbert E. White

(To Reference Committee No. 2)

Conservation of Vision, Ralph N. Greene, Jr.
Legislation and Public Policy, H. Phillip Hampton
Medical Education and Hospitals, Jack Q. Cleveland
Medical Economics, Reuben B. Chrisman, Jr.
State Controlled Medical Institutions, William D. Rogers
Representatives to Industrial Council, Charles R. Burbacher
Grievance, Walter C. Payne

(To Reference Committee No. 3)

Board of Governors, Robert B. McIver
Public Relations, Eugene B. Maxwell
Necrology, Alvin L. Stebbins
Advisory to Woman's Auxiliary, C. Robert DeArmas
Councilor Districts and Council, Eugene G. Peek, Jr.
Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell
Emergency Medical Service, James V. Freeman

Resolution: Alteration of regulations governing the physical requirements of physicians for entrance into the Armed Services — Duval County Medical Society.

Resolution: Evaluation of physical requirements for physicians being called into military service — Escambia County Medical Society.

New Business

Announcements

Adjournment

SECOND GENERAL SESSION

Tuesday, 11:30 a.m.

HOLLYWOOD BEACH HOTEL — MARDI GRAS ROOM

Call to Order, Robert B. McIver, President

Address (By Invitation), "Surgical Lesions of the Stomach, Duodenum and Jejunum and Their Management" (3¼" x 4" Slides), Frank Howard Lahey, Boston

Adjournment

Visit the exhibits. They represent a tremendous financial investment.

THIRD SCIENTIFIC ASSEMBLY

Tuesday, 2:30 to 5:15 p.m.

Hollywood Beach Hotel — Mardi Gras Room

2:30 p.m. "Ultrasonic Therapy: A Review of Its Present Status and Future Possibilities," Kenneth Phillips, Miami.
Discussion: Edward F. Carter, Sr., Tampa
Samuel B. Kleinman, Miami Beach

3:00 p.m. "Therapeutic Research with Radioisotopes" (3¼" x 4" Slides), Marshall Brucer, Chairman, Medical Division, Oak Ridge Institute of Nuclear Studies, Oak Ridge, Tenn.

3:30 p.m. "Treatment of Poisonous Snake Bites" (2" x 2" Slides), Edwin H. Andrews, Gainesville.
Discussion: C. B. Pollard, Ph.D., Professor of Chemistry, University of Florida, Gainesville
Julius Alexander, Miami

4:00 p.m. Recess

4:15 p.m. "Indications for Insulin in Diabetes Mellitus," H. Phillip Hampton, Tampa.
Discussion: Richard H. Sinden, St. Petersburg
Madison R. Pope, Plant City

4:45 p.m. "Adult Gaucher's Disease Complicated by Thrombocytopenic Purpura and Pregnancy," William P. Logan, Lakeland.
Discussion: James B. Leonard, Clearwater
John B. Ross, Jacksonville

REFERENCE COMMITTEES

Tuesday, 2:30 p.m.

Hollywood Beach Hotel

The three reference committees will meet on Tuesday at 2:30 p.m. in the Northeast Dining Room, Southwest Porch and Men's Card Room. The names of the delegates who have been appointed by President McIver to serve on reference committees are listed below:

1. HEALTH AND EDUCATION
NORTHEAST DINING ROOM
David R. Murphey, Jr., Chairman
John D. Milton
Erasmus B. Hardee
Herbert E. White
Jere W. Annis

2. PUBLIC POLICY
SOUTHWEST PORCH
Donald W. Smith, Chairman
Edward Jelks
Duncan T. McEwan
Francis T. Holland
N. Worth Gable

3. FINANCE AND ADMINISTRATION
MEN'S CARD ROOM
Frederick K. Herpel, Chairman
Samuel M. Day
Leigh F. Robinson
Walter C. Payne
Warren W. Quillian

ASSOCIATION DINNER

Tuesday, 7:00 p.m.

Hollywood Beach Hotel — Main Dining Room

Those who are not lodging at the headquarters hotel may obtain dinner tickets ($5.75 per person) from the hotel cashier.

VOUCHERS FOR PRIZES

At Association Dinner
Golf and Other Sports Events

WEDNESDAY

BOARD OF PAST PRESIDENTS

Wednesday, 8:00 a.m.

Hollywood Beach Hotel.

Main Dining Room, Northeast Section

William M. Rowlett, *Chairman*
David R. Murphey, Jr., *Secretary*

Breakfast

Election of a Chairman and Secretary

(According to precedence, Homer L. Pearson, Jr., will succeed the present chairman and Robert B. McIver, the present secretary.)

FOURTH SCIENTIFIC ASSEMBLY

Wednesday, 9:00 to 10:00 a.m.

Hollywood Beach Hotel — Mardi Gras Room

9:00 a.m. "Southern Florida and the Cardiac" (2" x 2" Slides), Sidney Davidson, Lake Worth.
Discussion: H. Milton Rogers, St. Petersburg
Milton S. Saslaw, Miami

9:30 a.m. "Hexamethonium Therapy in Hypertension," John S. McMichael, London, England

SECOND MEETING HOUSE OF DELEGATES

Wednesday, 10:30 a.m.

Hollywood Beach Hotel — Mardi Gras Room

Delegates sign official attendance cards at 10:00 a.m. at the table of Credentials Committee, Louis M. Orr, II, Chairman, James L. Borland and Herbert L. Bryans located at entrance to the Mardi Gras Room.
(No Alternates are to be seated for Delegates attending yesterday's meeting.)

President McIver in the Chair, 10:30 a.m.

Number of eligible Delegates present. Report by Louis M. Orr, II, Chairman, Credentials Committee.

Recommendations of Reference Committees:
No. 1. Health and Education
David R. Murphey, Jr., Chairman
No. 2. Public Policy
Donald W. Smith, Chairman
No. 3. Finance and Administration
Frederick K. Herpel, Chairman

Other unfinished business

Election of Association Officers, 12:00 noon
President-elect
First Vice President
Second Vice President
Third Vice President
Secretary-Treasurer
Editor of The Journal

Dr. Frederick K. Herpel escorted to the Chair as new President

Presentation of Past President's Button and Certificate of Honor to Dr. Robert B. McIver by Dr. Frederick K. Herpel, President

Adjournment

SPECIALTY GROUP MEETINGS

Saturday and Sunday, April 25-26

On July 25, 1948 the Board of Governors ruled that rooms be assigned to the various specialty group societies on Sunday, as heretofore, but that the State Association is not to furnish projecting lanterns or any of the equipment necessary for the holding of such meetings.

FIFTH ANNUAL MEETING
FLORIDA **ALLERGY** SOCIETY

OFFICERS

Nelson Zivitz, President ..... Miami Beach
James H. Putman, Vice Pres. & Pres.-elect ..... Miami
Solomon D. Klotz, Secy.-Treas. ..... Orlando

Sunday, April 26

HOLLYWOOD BEACH HOTEL — SPORTS CENTER

8:45 p.m.
1. "Oral Calcium Theophyllinate in the Treatment of Bronchial Spasm" (Preliminary report), Nelson Zivitz, Miami Beach.
   Discussion: Edwin P. Preston, Miami
   Solomon D. Klotz, Orlando
2. "Allergic Rhinitis," James H. Putman, Miami
   Discussion: Robert M. Oliver, Miami
   Frank C. Metzger, Tampa
   Frederick D. Droege, Sarasota
3. "Dosage Trends in Allergic Management—Theory and Practice," Clarence Bernstein, Orlando, Moderator.
   a. "Dermatological Aspects," George F. Hieber, St. Petersburg.
   b. "Pediatric Aspects," W. Ambrose McGee, West Palm Beach.
   c. "Otolaryngological Aspects," Joseph Feldman, Palm Beach.

Discussion is invited from the floor on all presentations.

FIFTH ANNUAL MEETING
FLORIDA SOCIETY OF **ANESTHESIOLOGISTS**

OFFICERS

John T. Stage, President ..... Jacksonville
Adelbert F. Schirmer, President-elect ..... Orlando
R. Gaylord Lewis, Vice President ..... West Palm Beach
Breckenridge W. Wing, Secy.-Treas. ..... Orlando

Sunday, April 26

HOLLYWOOD BEACH HOTEL — "A" DANCE STUDIO

2:00 p.m. Scientific Meeting
Business Meeting
Election of Officers

Scientific and technical exhibitors have arranged elaborate informational displays. Attendants will be on hand at each booth to explain their exhibit and to answer your questions.

FIFTH ANNUAL MEETING
FLORIDA CHAPTER
AMERICAN COLLEGE OF **CHEST PHYSICIANS**

OFFICERS

Alexander Libow, President ..... Miami Beach
Nathaniel M. Levin, Vice President ..... Miami
DeWitt C. Daughtry, Secy.-Treas. ..... Miami

Sunday, April 26

HOLLYWOOD BEACH HOTEL — FLAMINGO ROOM

9:30 a.m. Business Session
10:00 a.m. Scientific Session
1. "The Management of the Asthmatic," Maurice Kovnat, Miami Beach.
2. "Hemoptysis of Undetermined Origin," Nathaniel M. Levin, Miami.
3. "The Treatment of Pulmonary Tuberculosis with Isonicotinic Acid Alone and Combined with Other Antibiotics," Jack Reiss and George L. Baum, Coral Gables.
4. "INAH in the Treatment of Pulmonary Tuberculosis," Antonio Perez and Henry C. Sweany, Tampa.
5. "Papillomatosis of the Bronchial Tree," Burnett Schaff and Robert V. Thomson, Coral Gables.
6. "Concomitant Bronchogenic Carcinoma and Pulmonary Tuberculosis," Hawley H. Seiler, Tampa.
7. "Bronchial Adenoma," Ivan C. Schmidt, Lantana.

2:00 p.m. X-ray Conference

REGULAR MEETING OF THE FLORIDA ASSOCIATION OF
DERMATOLOGY AND **SYPHILOLOGY**

OFFICERS

Lewis Capland, President ..... Miami Beach
Joseph A. J. Farrington, Vice President ..... Jacksonville
Morris Waisman, Secy.-Treas. ..... Tampa

Sunday, April 26

Time and place to be announced

SEVENTH ANNUAL MEETING
FLORIDA ACADEMY OF **GENERAL PRACTICE**

OFFICERS

Edward F. Shaver, President ..... Tampa
Raymond R. Killinger, President-elect ..... Jacksonville
Paul J. Coughlin, Vice President ..... Tallahassee
Frank T. Linz, Secy.-Treas. ..... Tampa

Sunday, April 26

HOLLYWOOD BEACH HOTEL — THEATRE

8:00 p.m. Scientific Session

EIGHTH ANNUAL MEETING

FLORIDA **HEALTH OFFICERS'** SOCIETY

Officers

George W. Edwards, II, President — Orlando
Clarence L. Brumback, Vice President — West Palm Beach
Lorenzo L. Parks, Secy.-Treas. — Jacksonville

Sunday, April 26

Hollywood Beach Hotel — Southwest Porch

2:00 p.m. Scientific Session

1. "A Survey of Two Hundred Consecutive Physical Examinations," George W. Edwards, II, Orlando.
2. "Heart Disease a Community Health Problem," Simon D. Doff, Ponte Vedra Beach.
3. "The Sero-diagnosis of Syphilis," Sidney Olansky, Venereal Disease Research Laboratory, Chamblee, Ga.
4. "The Present Status of Arthropod-Borne Encephalitis," and "Leptospirosis in the United States," Morris Schaeffer, Virus and Rickettsia Laboratory, Montgomery, Ala.
5. "Questions and Answers on the Handling of Isotopes as a Public Health Problem," Marshall Brucer, Chairman, Medical Division, Oak Ridge Institute of Nuclear Studies, Oak Ridge, Tenn.
6. "Report on an Outbreak of Dysentery Among University Students," Joseph M. Bistowish, Jr., Tallahassee.
7. "Mortality Trends in Florida," Mr. Everett H. Williams, Jr., Director, Bureau of Vital Statistics, Jacksonville.
8. "The Role of the Health Officer and Physician in a Civil Defense Program," John M. Whitney, Chief Medical Officer, Civil Defense Administration, Region III, Atlanta.
9. "The Problems of a Tumor Clinic Director," Francis T. Holland, Tallahassee.
10. Business Session.

FOURTEENTH ANNUAL MEETING

FLORIDA ASSOCIATION OF

INDUSTRIAL AND **RAILWAY SURGEONS**

Officers

John H. Mitchell, President — Jacksonville
Lloyd J. Netto, President-elect — West Palm Beach
Plumer J. Manson, Vice President — Miami
William H. Chapman, Secy.-Treas. — Jacksonville

Sunday, April 26

Hollywood Beach Hotel — Sun Room

3:00 p.m. Scientific Session

1. "Hand Injuries," Henry C. Marble, Chief Surgeon, American Mutual Liability Insurance Company; Consulting Surgeon at the Massachusetts General Hospital, Chelsea Memorial Hospital and Veteran's Hospital, Boston.
2. "Diagnosis and Treatment of Low Back Injuries," Guy A. Caldwell, Chief of Orthopedic Surgery at the Oschner Clinic, New Orleans, and Professor of Orthopedic Surgery at Tulane University, New Orleans.

Business Session

Election of Officers

SEVENTH ANNUAL MEETING

FLORIDA SOCIETY OF

NEUROLOGY AND **PSYCHIATRY**

Officers

W. Tracy Haverfield, President — Miami
William H. McCullagh, Vice President — Jacksonville
Roger E. Phillips, Secy.-Treas. — Orlando

Sunday, April 26

Hollywood Beach Hotel — Stock Brokers' Room

4:00 p.m. Scientific Session.

1. "Clinical Applications of Carbon Dioxide Inhalations," James L. Anderson, Miami.

Business Meeting and Election of Officers.

SIXTH ANNUAL MEETING

FLORIDA **OBSTETRIC** AND **GYNECOLOGIC** SOCIETY

Officers

Dorothy D. Brame, President — Orlando
Ferdinand Richards, President-elect — Jacksonville
J. Champneys Taylor, Secy.-Treas. — Jacksonville

Sunday, April 26

Hollywood Beach Hotel — N. E. Dining Rooms

1:30 p.m. Business Session — Election of Officers
2:00 p.m. Scientific Session.

"Surgical Treatment of Gynecological Cancer," J. H. Pratt, Mayo Clinic, Assistant Professor of Surgery, University of Minnesota, Minneapolis.

FOURTEENTH ANNUAL MEETING

FLORIDA SOCIETY OF

OPHTHALMOLOGY AND **OTOLARYNGOLOGY**

Officers

Joseph W. Taylor, Sr., President — Tampa
Mozart A. Lischkoff, President-elect — Pensacola
G. Tayloe Gwathmey, 1st Vice President — Orlando
Charles W. Boyd, 2nd Vice President — Jacksonville
Carl S. McLemore, Secy.-Treas. — Orlando

Sunday, April 26

Hollywood Beach Hotel — Theatre

10:00 a.m. Scientific Session.

1. President's Address: Joseph W. Taylor, Sr., Tampa.
2. "Sore Tongue: Etiologic and Therapeutic Aspects," Abraham R. Hollender, Miami Beach.
3. "Post Operative Rupture of the Anterior Hyaloid Membrane After Intracapsular Cataract Surgery," Ralph E. Kirsch, Miami.
4. Business Meeting.
5. Annual Report of Florida Council for the Blind, Mr. Harry E. Simmons, Executive Director.

2:00 p.m. Scientific Session.

1. "Detachment of the Retina," James F. Shipman, Surgeon, Wills Eye Hospital, Philadelphia.
2. "Bronchography," James A. Harrill, Professor of Otolaryngology, Bowman Gray School of Medicine, Winston-Salem, N. C.

Election of Officers

SEVENTH ANNUAL MEETING

FLORIDA **ORTHOPEDIC** SOCIETY

OFFICERS

Arthur H. Weiland, President	Coral Gables
Charles R. Burbacher, Vice President	Coral Gables
Edward W. Cullipher, Secy.-Treas.	Miami

Sunday, April 26

HOLLYWOOD BEACH HOTEL — MARDI GRAS LOUNGE

2:00 p.m. Business Meeting
Election of Officers

ELEVENTH ANNUAL MEETING

FLORIDA SOCIETY OF **PATHOLOGISTS**

OFFICERS

Robert J. Poppiti, President	Miami Beach
Philipp R. Rezek, Vice President	Miami
Alfred E. Cronkite, Secy.-Treas.	Fort Lauderdale

Sunday, April 26

HOLLYWOOD BEACH HOTEL — SPORTS CENTER

9:30 a.m. General Business Session.
Election of New Members
Election of Officers
1:30 p.m. General Session.

FIFTEENTH ANNUAL MEETING

FLORIDA **PEDIATRIC** SOCIETY

OFFICERS

Charlotte C. Maguire, President	Orlando
C. Jennings Derrick, President-elect	West Palm Beach
Wesley S. Nock, Secy.-Treas.	Coral Gables

Sunday, April 26

HOLLYWOOD BEACH HOTEL — MEN'S CARD ROOM

2:00 p.m. Pediatric-Anesthesia Panel
1. "Basal Narcosis," Roger W. Gridley, Orlando, and Stanley H. Axelrod, Miami
2. "Anesthesia for Congenital Defects of the New-Born," Harold Carron, Miami
3. "Sudden and Unexpected Deaths in Infancy, C. G. Grulee, Jr., Associate Professor of Pediatrics, Tulane Medical School, New Orleans

Questions and Answers
Business Meeting

7:00 p.m. Dinner — Main Dining Room

8:00 p.m. "Fulminating Infections, Differential Diagnosis and Management," Margaret H. D. Smith, Microbiology Department and Lecturer in Pediatrics, Tulane Medical School, New Orleans.
Questions and Answers

SIXTH ANNUAL MEETING

FLORIDA **PROCTOLOGIC** SOCIETY

OFFICERS

Alexander E. Rosenberg, President	Miami Beach
Thomas F. Nelson, Vice President	Tampa
George Williams, Jr., Secy.-Treas.	Miami

Sunday, April 26

HOLLYWOOD BEACH HOTEL — "B" DANCE STUDIO

4:00 p.m. Business Meeting — (Fellows Only).

8:00 p.m. Scientific Meeting.

Symposium on Polyps of the Recto-Colon
1. "X-Ray Diagnosis of Recto-Colonic Polyps," Oliver P. Winslow, Jr., Miami.
2. "Clinical Diagnosis and Therapy of Polyps," John J. Cheleden, Daytona Beach.
3. "Pathology of Recto-Colonic Polyps," Maurice Lev, Miami Beach, Pathologist and Director of Research Division, Mt. Sinai Hospital.

TWENTY-SECOND ANNUAL SPRING MEETING

FLORIDA **RADIOLOGICAL** SOCIETY

OFFICERS

Thoams H. Lipscomb, President	Jacksonville
Nelson T. Pearson, Vice President	Miami
A. Judson Graves, Secy.-Treas.	Jacksonville

Saturday, April 25

HOLLYWOOD BEACH HOTEL — THEATRE

2:00 p.m. Round Table Discussion — Diagnosis

Sunday, April 26

HOLLYWOOD BEACH HOTEL — MEN'S CARD ROOM

10:00 a.m. Business Session and Election of Officers

SIXTH ANNUAL MEETING

FLORIDA **UROLOGICAL** SOCIETY

OFFICERS

George H. Putnam, President	Gainesville
Frank M. Woods, President-elect	Miami
David W. Goddard, Secy.-Treas.	Daytona Beach

Sunday, April 26

HOLLYWOOD BEACH HOTEL — MARDI GRAS ROOM

2:00 p.m. 1. "Surgical Treatment of Vesical Ectopy and the Handling of Some Complications," George F. Cahill, New York City.
2. "Pyelographic Clinic," George F. Cahill, New York City, Moderator.
3. Business Meeting.
4. Election of Officers.
5. Cocktail Party.

ANNUAL MEETING

FLORIDA **CANCER** COUNCIL

Ashbel C. Williams, Chairman	Jacksonville
Lorenzo L. Parks, Secretary	Jacksonville
Frazier J. Payton	Miami
George W. Morse	Pensacola
C. Frank Chunn	Tampa
Wilson T. Sowder	Jacksonville
Duncan T. McEwan	Orlando

Sunday, April 26

HOLLYWOOD BEACH HOTEL — PARLOR 546

8:00 p.m. Business Meeting

EIGHTH ANNUAL MEETING

BLUE SHIELD OF FLORIDA

Officers

Leigh F. Robinson, President ..... Fort Lauderdale
Duncan T. McEwan, 1st Vice President ..... Orlando
Jack O. W. Rash, 2nd Vice President ..... Miami
Frederick J. Waas, Treasurer ..... Jacksonville
Samuel M. Day, Asst. Treasurer ..... Jacksonville
Herbert E. White, Secretary ..... St. Augustine

Wednesday, April 29

Hollywood Beach Hotel — N. E. Dining Rooms
2:00 p.m. Dr. Robinson presiding

THE TECHNICAL EXHIBIT

One feature that always adds materially to the success of an annual meeting is the technical exhibit. Every firm represented in the display features products of particular interest to the physician. Make a special effort to visit each booth at some time during the convention and register your name with the attending representative.

The Technical Exhibit Hall will be open Sunday, Monday, and Tuesday, 8:30 a.m. to 5:30 p.m. On Wednesday it will be open 8:30 a.m. to closing time, 12:30 p.m., following which booths may be dismantled.

Burroughs Wellcome & Co, Inc. — 1

AEROSPORIN® OTIC SOLUTION STERILE has a wide anti-bacterial action, and is especially effective against Ps. aeruginosa. It consists of Aerosporin® Sulfate Polymyxin B Sulfate in acidified proplyene glycol. It is hygroscopic, and has a low surface tension. POLYSPORIN® POLYMYXIN B — BACITRACIN OINTMENT has a broad antibacterial action. Used for treating pyogenic conditions of the eye and skin, and infected lesions. Also for preventing infections in clean wounds and burns.

Westinghouse Electric Corp., X-Ray Division — 2

Ames Company, Inc. — 3

APROMAL — non-narcotic, non-barbiturate sedative (acetylcarbromal) plus N-acetyl-p-aminophenol. DECHOLIN SODIUM is foremost in combatting serum-sickness type penicillin reactions. Dramatic patient-relief has been noted within a few hours after intravenous DECHOLIN SODIUM, followed by adequate oral DECHOLIN

Lederle Laboratories Division — 4

You are cordially invited to visit our exhibit in Booth No. 4 where you will find representatives who are prepared to give you the latest information on LEDERLE products.

Tablerock Laboratories — 5

Wm. S. Merrell Company — 6

For prompt, effective and comfortable relaxation of gastrointestinal smooth muscle spasm, Merrell presents BENTYL Hydrochloride. BENTYL is a high milligram potency non-narcotic antispasmodic with two-fold musculotropic and neurotropic action. BENTYL is therapeutically effective in functional gastrointestinal disorders without atropine-like side actions. BENTYL is particularly suited for prolonged administration without habituation or increased tolerance.

National Drug Company — 7

Kelleket X-Ray of Florida — 8

Chicago Pharmacal Company — 9

The Chicago Pharmacal Company (Chimedic products) welcomes your visit to Booth No. 9, which features the following products: URISED, nationally-known urinary antiseptic and sedative tablet; TOLYPHY, another Chimedic first, a tablet combining a full 0.5 gram of mephenesin plus physostigmine and atropine, for a wider range of muscular relaxation than ever before; and BEXII-M and BEXIIFORT injectibles, 10 cc. vials containing respectively, 1000 mcg. (1 mg.) Vitamin B 12 Crystalline, U.S.P. per cc. and 100 mcg. Vitamin B 12 Crystalline, U.S.P. per cc.

C. B. Fleet Company — 10

C. B. Fleet Co., Inc., cordially invites you to stop at Booth 10 to see the exhibit of Phospho-Soda (Fleet). Phospho-Soda (Fleet) is a solution containing in each 100 cc. sodium biphosphate 48 gm. and sodium phosphate 18 gm. There is only one Phospho-Soda (Fleet).

The Coca-Cola Company — 11-12

Blairs Braces, Inc. — 13

R. J. Lindquist Co. — 16

Baby Development Clinic — 17

A. H. Robins Company, Inc. — 18

The A. H. Robins Company (Booth 18) is presenting Robalate, brand of Dihydroxy Aluminum Aminoacetate, N.N.R. The previously reported rapid and prolonged buffering action of this antacid has been confirmed in a new study by Robert S. Murphey (J. Amer. Pharm. Assoc., Scie. Ed., July, 1952). The study further discloses that, unlike dried aluminum hydroxide gel, the antacid action of dihydroxy aluminum aminoacetate is not significantly affected by time nor inhibited by pepsin.

Winthrop-Stearns, Inc. — 19

Winthrop-Stearns, Inc., New York, invite you to visit booth No. 19, where the following products will be featured — APOLAMINE, for more efficient control of nausea and vomiting due to pregnancy, radiation sickness, and other causes; ALEVAIRE, nontoxic inhalant which thins sticky pulmonary secretions in bronchitis, bronchiectasis, and neo-natal asphyxia; MEBAROIN, efficient, well tolerated antiepileptic combination of Mebaral and diphenylhydantoin.

(Continued on page 693)

FLORIDA MEDICAL ASSOCIATION

OFFICERS AND COMMITTEES

OFFICERS

ROBERT B. MCIVER, M.D., President.....*Jacksonville*
FREDERICK K. HERPEL, M.D., Pres.-elect..*West Palm Beach*
FRANCIS H. LANGLEY, M.D., 1st Vice Pres...*St. Petersburg*
ERASMUS B. HARDEE, M.D., 2nd Vice Pres.....*Vero Beach*
H. QUILLIAN JONES, M.D., 3rd Vice Pres.....*Fort Myers*
SAMUEL M. DAY, M.D., Sec'y-Treas.....*Jacksonville*
SHAFER RICHARDSON, M.D., Editor.....*Jacksonville*

MANAGING DIRECTOR

STEWART G. THOMPSON, D.P.H.....*Jacksonville*
ERNEST R. GIBSON, Assistant.....*Jacksonville*

BOARD OF GOVERNORS*

ROBERT B. MCIVER, M.D., Chm...(Ex Officio).*Jacksonville*
JAMES L. BORLAND, M.D...AL-53.....*Jacksonville*
DUNCAN T. MCEWAN, M.D...B-53.....*Orlando*
JAMES H. POUND, M.D...A-54.....*Tallahassee*
NORVAL M. MARR, M.D...C-55.....*St. Petersburg*
JOHN D. MILTON, M.D...D-56.....*Miami*
HERBERT E. WHITE, M.D...PP-53.....*St. Augustine*
DAVID R. MURPHEY, JR., M.D...PP-54.....*Tampa*
FREDERICK K. HERPEL, M.D. (Ex Officio).*W. Palm Beach*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*
HERBERT L. BRYANS, M.D...S.B.H.-53.....*Pensacola*
STEWART G. THOMPSON, D.P.H. (Advisory)...*Jacksonville*

*SUB-COMMITTEES

1. Veterans Care

FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
GEORGE M. STUBBS, M.D.....*Jacksonville*
DOUGLAS D. MARTIN, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

2. Advisory to National Foundation Infantile Paralysis

FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
H. PHILLIP HAMPTON, M.D.....*Tampa*
ROBERT P. KEISER, M.D.....*Coral Gables*
RICHARD G. SKINNER, JR., M.D.....*Jacksonville*

3. Review of Fee Schedules

JOHN D. MILTON, M.D., Chm.....*Miami*
WOODROW B. ESTES, M.D.,.....*St. Petersburg*
FREDERICK H. BOWEN, M.D.....*Jacksonville*
ODIS G. KENDRICK, JR., M.D.....*Tallahassee*
JAMES B. GLANTON, M.D.....*Orlando*
FLOYD K. HURT, M.D.....*Jacksonville*
HERSCHEL G. COLE, M.D.....*Tampa*
A. FRANKLIN HARRISON, M.D.....*Madison*
JACK O. W. RASH, M.D.....*Miami*
KENNETH S. WHITMER, M.D.....*Miami*
ADELBERT F. SCHIRMER, M.D.....*Orlando*

4. Blue Shield

LEIGH F. ROBINSON, M.D., Chm.....*Fort Lauderdale*

SCIENTIFIC WORK

JAMES N. PATTERSON, M.D., Chm...AL-53.....*Tampa*
CAROL C. WEBB, M.D...A-53.....*Pensacola*
FREDERICK K. HERPEL, M.D...D-54.....*West Palm Beach*
JERE W. ANNIS, M.D...C-55.....*Lakeland*
RICHARD C. CUMMING, M.D...B-56.....*Ocala*

LEGISLATION AND PUBLIC POLICY

H. PHILLIP HAMPTON, M.D., Chm...B-53.....*Tampa*
WILLIAM M. ROWLETT, M.D...AL-53.....*Tampa*
DANIEL A. MCKINNON, M.D...A-53.....*Marianna*
ANGUS D. GRACE, M.D...C-55.....*Fort Myers*
DONALD W. SMITH, M.D...D-56.....*Miami*
ROBERT B. MCIVER, M.D. (Ex Officio).....*Jacksonville*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*

MEDICAL EDUCATION AND HOSPITALS*

JACK Q. CLEVELAND, M.D., Chm...AL-53.....*Coral Gables*
JULIUS C. DAVIS, M.D...A-53.....*Quincy*
ELBERT MCLAURY, M.D...D-54.....*Hollywood*
S. CARNES HARVARD, M.D...C-55.....*Brooksville*
BENJAMIN F. DICKENS, M.D...B-56.....*Fernandina*

*SPECIAL ASSIGNMENT

1. Urge Gifts to American Medical Education Foundation

PUBLIC RELATIONS*

EUGENE B. MAXWELL, M.D., Chm...AL-53.....*Tampa*
LEIGH F. ROBINSON, M.D...D-53.....*Fort Lauderdale*
HOWARD V. WEEMS, SR., M.D...C-54.....*Sebring*
EUGENE G. PEEK, JR., M.D...B-55.....*Ocala*
HENRY L. SMITH, JR., M.D...A-56.....*Tallahassee*

*SPECIAL ASSIGNMENTS

1. Rural Educational Program
2. State Education Campaign

NECROLOGY

ALVIN L. SIEBBINS, M.D., Chm...A-56.....*Pensacola*
HUGH WEST, M.D...AL-53.....*Deland*
JOSEPH HALTON, M.D...C-53.....*Sarasota*
WALLACE H. MITCHELL, M.D...D-54.....*Key West*
JOSEPH J. LOWENTHAL, M.D...B-55.....*Jacksonville*

MEDICAL POSTGRADUATE COURSE

TURNER Z. CASON, M.D., Chm...B-55.....*Jacksonville*
ARTHUR J. BUTT, M.D...AL-53.....*Pensacola*
FRANZ H. STEWART, M.D...D-53.....*Miami*
J. BROWN FARRIOR, M.D...C-54.....*Tampa*
FRANCIS T. HOLLAND, M.D...A-56.....*Tallahassee*

CANCER CONTROL

FRAZIER J. PAYTON, M.D., Chm...D-54.....*Miami*
MILTON C. MALONEY, M.D...AL-53.....*Jacksonville*
ROBERT L. TOLLE, M.D...B-53.....*Orlando*
GEORGE W. MORSE, M.D...A-55.....*Pensacola*
WESLEY W. WILSON, M.D...C-56.....*Tampa*

MEDICAL ECONOMICS

REUBEN B. CHRISMAN, JR., M.D., Chm...AL-53....*Miami*
JOHN E. MAINES, JR., M.D...B-53.....*Gainesville*
HARRISON A. WALKER, M.D...D-54.....*Miami*
WILLIAM H. WALTERS, JR., M.D...C-55.....*Lacoochee*
WILLIAM C. ROBERTS, M.D...A-56.....*Panama City*

VENEREAL DISEASE CONTROL

MELVIN M. SIMMONS, M.D., Chm...C-55.....*Sarasota*
JOHN R. BROWNING, M.D...AL-53.....*Jacksonville*
JOHN C. MCSWEEN, JR., M.D...A-53.....*Pensacola*
WILEY M. SAMS, M.D...D-54.....*Miami*
DAVID W. GODDARD, M.D...B-56.....*Daytona Beach*

TUBERCULOSIS AND PUBLIC HEALTH*

RALPH S. SAPPENFIELD, M.D., Chm...AL-53.....*Miami*
PHILLIP W. HORN, M.D...B-53.....*Jacksonville*
ERASMUS B. HARDEE, M.D...D-54.....*Vero Beach*
LOUIS J. GARCIA, M.D...C-55.....*Tampa*
HARRY S. HOWELL, M.D...A-56.....*Lake City*

*SPECIAL ASSIGNMENT

1. Diabetes Control

STATE CONTROLLED MEDICAL INSTITUTIONS

William D. Rogers, M.D., Chm...A-56....*Chattahoochee*
James L. Anderson, M.D...AL-53.....*Miami*
Bailey B. Sory, Jr., M.D...D-53.....*Palm Beach*
James G. Lyerly, M.D...B-54.....*Jacksonville*
Samuel G. Hibbs, M.D...C-55.....*Tampa*

MATERNAL WELFARE

F. Frank McCall, M.D., Chm...B-56.....*Jacksonville*
F. Bert Fletcher, Jr., M.D...AL-53.....*Tallahassee*
Lowrie W. Blake, M.D...C-53.....*Bradenton*
John N. Sims, Sr., M.D...A-54.....*Live Oak*
Ralph W. Jack, M.D...D-55.....*Miami*

CHILD HEALTH

Luther W. Holloway, M.D., Chm...B-53....*Jacksonville*
James R. Boulware, Jr., M.D...AL-53.....*Lakeland*
Warren W. Quillian, M.D...D-54.....*Coral Gables*
Daniel F. H. Murphey, M.D...C-55.....*St. Petersburg*
Courtland D. Whitaker, M.D...A-56.....*Marianna*

CONSERVATION OF VISION

Ralph N. Greene, Jr., M.D., Chm...AL-53..*Jacksonville*
William Y. Sayad, M.D...D-53.....*West Palm Beach*
Sherman B. Forbes, M.D...C-54.....*Tampa*
G. Taylor Gwathmey, M.D...B-55.....*Orlando*
Mozart A. Lischkoff, M.D...A-56.....*Pensacola*

ADVISORY TO WOMAN'S AUXILIARY

C. Robert DeArmas, M.D., Chm...B-55....*Daytona Beach*
Benjamin H. Sullivan, M.D...AL-53.....*St. Petersburg*
Edward F. Shaver, M.D...C-53.....*Tampa*
James L. Anderson, M.D...D-54.....*Miami*
Taylor W. Griffin, M.D...A-56.....*Quincy*

REPRESENTATIVES TO INDUSTRIAL COUNCIL*

Charles R. Burbacher, M.D., Chm...D-55..*Coral Gables*
Fred H. Alree, Jr., M.D...AL-53.....*Orlando*
G. Frederick Oetjen, M.D...B-53.....*Jacksonville*
Chas. L. Farrington, M.D...C-54.....*St. Petersburg*
Lee Sharp, M.D...A-56.....*Pensacola*

*SPECIAL ASSIGNMENT
1 *Industrial Health*

COUNCILOR DISTRICTS AND COUNCIL

Eugene G. Peek, Jr., M.D., Chm...AL-53.....*Ocala*
First—Francis M. Watson, M.D...1-54.....*Marianna*
Second—Benjamin A. Wilkinson, M.D...2-53..*Tallahassee*
Third—William C. Thomas, Jr., M.D...3-54..*Gainesville*
Fourth—Eugene L. Jewett, M.D...4-53.....*Orlando*
Fifth—Hugh G. Reaves, M.D...5-53.....*Sarasota*
Sixth—Emmett E. Martin, M.D...6-54.....*Haines City*
Seventh—Erasmus B. Hardee, M.D...7-54....*Vero Beach*
Eighth—Donald W. Smith, M.D...8-53.....*Miami*

GRIEVANCE COMMITTEE

Walter C. Payne, M.D., Chm.....*Pensacola*
David R. Murphey, Jr., M.D.....*Tampa*
Herbert E. White, M.D.....*St. Augustine*
Joseph S. Stewart, M.D.....*Miami*
William C. Thomas, Sr., M.D.....*Gainesville*

ADVISORY TO SELECTIVE SERVICE FOR PHYSICIANS AND ALLIED SPECIALISTS

J. Rocher Chappell, M.D., Chm.....*Orlando*
Thomas H. Bates, M.D..."A".....*Lake City*
Frank L. Fort, M.D..."B".....*Jacksonville*
Alvin L. Mills, M.D..."C".....*St. Petersburg*
John D. Milton, M.D..."D".....*Miami*

EMERGENCY MEDICAL SERVICE

James V. Freeman, M.D., Chm.....*Jacksonville*
Merritt R. Clements, M.D..."A".....*Tallahassee*
Vernon A. Lockwood, M.D..."B".....*St. Augustine*
Herschel G. Cole, M.D..."C".....*Tampa*
Frederick K. Herpel, M.D..."D".....*West Palm Beach*

A.M.A. HOUSE OF DELEGATES

Louis M. Orr, II, M.D., Delegate.....*Orlando*
Joshua C. Dickinson, M.D., Alternate.....*Tampa*
(Terms expire Dec. 31, 1953)
Reuben B. Chrisman, Jr., M.D., Delegate.....*Miami*
Frank D. Gray, M.D., Alternate.....*Orlando*
(Terms expire Dec. 31, 1954)
Herbert L. Bryans, M.D., Delegate.....*Pensacola*
Thomas H. Bates, M. D., Alternate.....*Lake City*
(Terms expire Dec. 31, 1954)

BOARD OF PAST PRESIDENTS

William E. Ross, M.D., 1919.....*Jacksonville*
H. Marshall Taylor, M.D., 1923.....*Jacksonville*
John C. Vinson, M.D., 1924.....*Fort Myers*
John S. McEwan, M.D., 1925.....*Orlando*
H. Mason Smith, M.D., 1926.....*Tampa*
John A. Simmons, M.D., 1927.....*Arcadia*
Frederick J. Waas, M.D., 1928.....*Jacksonville*
Julius C. Davis, M.D., 1930.....*Quincy*
William M. Rowlett, M.D., Chm., 1933.....*Tampa*
Homer L. Pearson, Jr., M.D., 1934.....*Miami*
Herbert L. Bryans, M.D., 1935.....*Pensacola*
Orion O. Feaster, M.D., 1936.....*Renton, Wash.*
Edward Jelks, M.D., 1937.....*Jacksonville*
Leigh F. Robinson, M.D., 1939.....*Fort Lauderdale*
Walter C. Jones, M.D., 1941.....*Miami*
Eugene G. Peek, Sr., M.D., 1943.....*Ocala*
John R. Boling, M.D., 1944, 1945.....*Tampa*
Shaler Richardson, M.D., 1946.....*Jacksonville*
William C. Thomas, Sr., M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne, M.D., 1949.....*Pensacola*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey, Jr., M.D., Sec'y., 1951.....*Tampa*

From Our President

The Greatest Instrument of All

To the patient in the operating room, most of the people who surround him will never be known, despite the fact that he may owe his life to the coordination of their hands and skills. They come into his life after he is anesthetized; when he comes to, they are gone. Great have been the technologic advances made in the tools of surgery. Skilled fingers manipulate these tools in intricate and extremely delicate procedures. But hands and tools suggest that which is even more important than these alone — a superb interworking of human minds and skills. The greatest surgical instrument of all is now and ever will be the surgery team.

Engrossedly, the surgeons work with heavy concentration. About them, others, knowing their tasks, must anticipate their needs and work so as not to distract them. Actions are meshed with sure smoothness. Many are the essential hands which contribute to the operation's success — magnificent the teamwork. Likewise, many are the incredible improvements in surgical technics since the advent of the sulfonamides and the antibiotics, many are the years added to the life expectancy of the aging.

Transplanting the wizardy of the surgery team to broader human relations, may not one look forward to a better world wherein greater human understanding of humanity itself shall govern? Advances in the early detection of cancer, diabetes and tuberculosis, steps toward the establishment of more widespread and efficient blood banking, these are but a few items which provide a more hopeful outlook for the public than ever before. But the greatest hope lies in better human understanding, better teamwork, greater sharing of that added wisdom which comes from broader experience.

Such sharing, not alone at county, state and national levels, but particularly across international boundaries, surmounting language barriers, transcending differing ideologies, augurs well for the patient of whatever nation or clime and also for sick humanity as a whole. The medical profession is grasping its peculiar opportunity to exercise leadership toward this goal of greater human understanding of humanity. Last month the first Inter-American Session of the American College of Surgeons took place in Sao Paulo, Brazil — teamwork with our South American neighbors rich in potential international good. Steadily, effectively, and cooperatively the World Medical Association, the World Health Organization and the American Medical Association are working with many medical and nonmedical groups throughout the world to translate ideal concepts into practical results.

In such a venture one does not anticipate spectacular results. Like the patient in the operating room, the sick world may never know who saved it. Nevertheless, every American surgeon, every American physician, has a role beyond his immediate sphere as ambassador of good will both at home and abroad. It is the personal touch, the individual relationship of man to man, that alone perhaps, but certainly best of all, can keep alive a springtime freshness in the free world. The meeting of minds in sympathetic understanding — that is the greatest instrument of all for health and peace in this troubled world.

Frank Howard Lahey, M.D., Guest Speaker

Dr. Frank Howard Lahey was born in Haverhill, Mass., on June 1, 1880. He received his medical degree from Harvard Medical School in 1904. An internship at Boston City Hospital was followed by a year at Long Island Hospital and then surgical service at the Boston City Hospital for two years.

From 1913 to 1917, Dr. Lahey was Professor of Surgery at Tufts College and during 1923-1924 was Professor of Clinical Surgery at Harvard Medical School. He is Director of The Lahey Clinic, Boston, Surgeon-in-Chief to the New England Baptist Hospital and Surgeon to the New England Deaconess Hospital. A member of the Council on National Emergency Medical Service, he is also a trustee of the National Fund for Medical Education.

During World War I, as a major in the Medical Corps Dr. Lahey served as Director of Surgery in Evacuation Hospital No. 30, AEF, and in World War II he was National Chairman of the Directing Board for Procurement and Assignment Service for the Armed Forces and Chairman of the Medical Consulting Board of the United States Navy. By appointment of President Roosevelt, he became Chairman for Revision of Physical Standards in 1944, and the following year he was appointed to the Committee on Integration of Medical Services in the Government by President Truman.

This internationally famous surgeon is a past president of the American Medical Association, the New England Surgical Association and the Interstate Postgraduate Medical Association, a Governor of the American College of Surgeons, and a member of numerous surgical societies. He is the recipient of several honorary degrees, and of a number of medals from medical organizations. In 1946 he was awarded the Medal for Merit by the Secretary of the Navy and the Certificate of Merit by President Truman. In 1947 he was elected to Honorary Fellowship in the Royal College of Surgeons of England and was presented the Degree of the College. A recent honor was the Nicaraguan Medal for Merit in 1951.

Dr. Lahey is an important contributor to surgical literature and has been cited for outstanding work in the advancement of anesthesia.

VOLUME XXXIX
NUMBER 9

The Journal of the Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION

P. O. BOX 1018 JACKSONVILLE, FLORIDA

Editor
Shaler Richardson, M.D.

Assistant Editors
Webster Merritt, M.D.
Franz H. Stewart, M.D.

Associate Editors

Louis M. Orr, II, M.D. ..... Orlando
Joseph J. Lawenthal, M.D. ..... Jacksonville
Jere W. Annis, M.D. ..... Lakeland
Herschel G. Cale, M.D. ..... Tampa
Wilson T. Sawder, M.D. ..... Jacksonville
Carlos P. Lamar, M.D. ..... Miami
Walter C. Payne, M.D. ..... Pensacola

Managing Editor
Stewart G. Thompson, D.P.H.
Ernest R. Gibson, Asst.

Committee on Publication

Shaler Richardson, M.D., Chairman ..... Jacksonville
Chas. J. Callins, M.D. ..... Orlando
James N. Patterson, M.D. ..... Tampa

Abstract Department

Kenneth A. Morris, M.D., Chairman ..... Jacksonville
Walter C. Janes, M.D. ..... Miami

Seventy-Ninth Annual Meeting

The beautiful new Mardi Gras Room will be the scene of the two General Sessions, four Scientific Assemblies and the two meetings of the House of Delegates of the seventy-ninth annual meeting of the Florida Medical Association, April 27-29. All activities will again be housed in the spacious Hollywood Beach Hotel. The hotel will provide transportation to its golf course for the members participating in the handicap tournament. The complete program is published in preceding pages of this number of The Journal.

This year will see seventeen specialty groups convening during the weekend preceding the opening of the Association's meeting. All groups will hold one or more sessions on Sunday. One specialty society is scheduled for Saturday as well. The Eighth Annual Meeting of the Blue Shield of Florida has been scheduled for Wednesday, April 29, at 2:00 p.m. Each group has been assigned a meeting room of such size as will be adequate for the attendance anticipated. The program for each of these groups appears in this issue.

Dr. James N. Patterson, chairman of the Association's Committee on Scientific Work, together with the members of his committee, Drs. Carol C. Webb, Frederick K. Herpel, Jere W. Annis and Richard C. Cumming, has prepared the program for the scientific assemblies. Four scientific assemblies have been scheduled, one each on Monday forenoon and afternoon and on Tuesday afternoon and Wednesday morning.

Dr. Robert B. McIver will deliver his presidential address at the first meeting of the House of Delegates on Tuesday morning. Following the meeting of the first House of Delegates on Tuesday, the guest speaker, Dr. Frank H. Lahey of Boston, will read his paper at the second general session.

Dr. Russell B. Carson, chairman of the Smoker Committee, his co-chairman, Dr. David R. Murphey, Jr., and the members of his committee, Drs. E. Frank McCall, Whitman C. McConnell, Raymond B. Squires, William M. Howdon and Norman E. Williams, have completed arrangements for the annual Smoker on Monday night, April 27. This year the Smoker Committee is arranging a millionaires party. Another event of the same evening at 6:00 p.m. will be the Alumni and Fraternity Suppers in the hotel dining rooms.

The annual dinner of the Association is scheduled for Tuesday night at the hotel. In addition to participating in these social events featured annually, the members and their guests will have opportunity for diversified entertainment and recreation which will include golf, ocean and pool bathing, fishing, and sea or shore excursions.

In the Arcade on the ground floor there will be a new feature this year, a coffee shop called the

"Rendezvous," which will serve meals at popular prices.

The Great Lounge of the hotel overlooking the ocean has been given over to the technical exhibits. All scientific exhibits will be displayed in the Arcade on the ground floor. They will present a wealth of information of value to specialists and general practitioners alike. The numerous technical exhibits will invite careful inspection. Attendants will be on hand at each booth to answer questions on the latest developments in equipment, drugs and other products displayed by the exhibiting firms.

Notice to Delegates and Committee Chairmen

The House of Delegates will hold its first 1953 meeting on Tuesday, April 28, at 9:30 a.m. in the Mardi Gras Room of the Hollywood Beach Hotel. The delegates are requested to assemble at the Credentials Committee table at 9:00 a.m. to present their credentials, fill out attendance cards and receive special badges. This table will be located at the entrance to the Mardi Gras Room. Delegates are to occupy seats in the front section in order that they may be grouped together. Other members of the Association and guest doctors are requested to occupy seats in the rear section of the room.

Chairmen of standing committees are urgently requested to be present on time so that their reports may be presented as scheduled in the official program, which is published in this issue of The Journal. Resolutions not included in the House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the Speaker's table immediately after they are presented.

It is highly important that delegates and committee chairmen note the time, the date and the place of this first meeting of the House of Delegates. Register at 9:00 a.m. and convene at 9:30 a.m., Tuesday, April 28, in the Mardi Gras Room of the Hollywood Beach Hotel.

The second meeting of the House of Delegates will be held Wednesday, April 29, at 10:30 a.m. Delegates are required to fill out attendance cards for this meeting at 10:00 a.m. at the entrance to the Mardi Gras Room. These cards are the delegates' official attendance records. The By-Laws prohibit an alternate from serving for any delegate who was seated at the first meeting of the House.

At 12:00 noon on Wednesday, at this second meeting of the House, the election of officers of the Association for the ensuing year will take place.

Influenza and Pneumonia

Hazards to life all the year around, influenza and pneumonia offer particular risk in the winter and spring. About three fifths of the deaths occur in the period from December through April,[1] and this year with its excessive number of cases will doubtless be no exception.

The favorable trend in the death rate from these diseases began a decade and a half ago with the advent of the sulfonamides and has continued with the antibiotics. Fatalities have declined by about one half in the past eight years and nearly three fourths since 1936.[1]

Nevertheless, in 1951 influenza and pneumonia caused over 51,000 deaths in this country including some 3,000 from pneumonia in babies under four weeks of age. Outranked only by the cardiovascular-renal conditions and cancer, these diseases claimed approximately 21,000 more lives than did tuberculosis.[1]

The mortality is highest among the very old and the very young. Also, it is materially higher among males than females. Particularly is the sex difference pronounced in the period just past midlife, for among white persons at ages 45 to 54, the rate for men is more than three times that for women. The ratio of the Negro to the white death rate is 2.2 to 1 among males and higher still among females. Factors influencing these ratios somewhat are of course occupational exposure, differences in living and working conditions, and availability of medical care.[1-3]

Rising steadily from a minimum in August and September, deaths from influenza and pneumonia reach a peak in the late winter or early spring and then return to their summer low. It is noteworthy that the seasonal distribution of deaths from all causes combined parallels that for the respiratory infections. Pneumonia continues to be a major killer.

The present prevalence of influenza, however mild, not alone in this country but around the world, is a sharp reminder that there is no guarantee against a major epidemic striking anywhere any time, as has happened at times in the past. The realization that various forms of the respiratory diseases are not amenable to specific therapy and that there are as yet no effective immuniza-

tion procedures remains a challenge. It is evident that these infections are a public health problem of major proportions, of which the medical profession needs to keep constantly aware.

1. Pneumonia Still a Major Killer, Statist. Bull. Metrop. Life Insur. Co. 33:9-10 (Nov.) 1952.
2. Pneumonia and Influenza, New York State J. Med. 53:155-156 (Jan. 15) 1953.
3. Continued Perils of Pneumonia and Influenza, J. A. M. A. 151:388 (Jan. 31) 1953.

Approval for Internships Changed

The internship in its broadest aspects was the subject of careful study last year by an Advisory Committee on Internship of the Council on Medical Education and Hospitals of the American Medical Association. The recommended revisions in the "Essentials of an Approved Internship" were ratified by the House of Delegates at the A.M.A. Clinical Session in Denver last December.

Changes in the requirements for hospitals offering intern programs include approval by the Joint Commission on Accreditation of Hospitals: bed capacity increased to 150, excluding bassinets; annual admissions increased to 5,000, exclusive of the newborn, and the autopsy rate increased to 25 per cent.

The Council will approve, under these revisions, rotating and mixed internships and straight internships in these specialties — internal medicine, pediatrics and surgery. It will no longer approve straight internships in pathology and obstetrics-gynecology.

For new approvals, the revised "Essentials" became effective January 1 of this year, as did also the autopsy rate of 25 per cent for all hospitals.

Comparable Hourly Earnings for Physician and Skilled Laborer

Did you ever compute your hourly base pay, Doctor? Although familiar to most Americans today, the concept of overtime work at overtime pay is seldom applied to a profession like medicine. Such application, however, might prove enlightening, both in general and in the individual case.

In its January 1953 issue, Medical Economics published the results of a nationwide survey of medical practice, based on a questionnaire sent to its 134,000 physician readers. The survey disclosed that the average family physician had in 1951 a net income of $14,098, before taxes, a figure which does not take into account the extra hours the typical physician puts in. So computing the average family doctor's hourly base pay, assuming time-and-a-half for overtime and double time for Sunday work, was the next step.

Since, according to the survey, the family doctor works an average of 62 hours a week, 22 of these hours must be counted as overtime. Perhaps five of these hours represent Sunday work. For pay purposes, then, he should be credited with about 75 hours a week, or 3,750 a year. On the basis of an annual net income of $14,098 and 3,750 hourly credits for the year, his hourly base pay would be $3.76.

It would appear from this computation that the hourly return of the skilled union laborer and the typical physician is roughly the same. Many bricklayers, for example, now receive $3.25 an hour. "And if other workers earn less," asks the magazine, "and if medical specialists earn more, isn't this explainable in terms of degree of specialized skill?"

How Much for Operating Expenses, Doctor?

If you are an average physician in private practice, you spent $9,508 on operating expenses in 1951. That was two fifths of your gross income.

A recent survey by Medical Economics, reported in the January 1953 number, revealed these and other arresting figures regarding the average doctor's professional expenses. These expenses rose 24 per cent from 1947 to 1951, for they were only $7,200 in 1947. A major item was office assistants' salaries, costing $2,689 in 1951. Other expense items were drugs and supplies, $1,966; office rent, $1,149; automobile upkeep, $882; and instruments and equipment, $661.

This inquiry determined that doctors in small towns as a rule spend a higher percentage of their gross income on expenses than physicians in the large metropolitan areas. Also, operating costs tend to be proportionately higher among physicians with low incomes than among their colleagues with incomes in the upper brackets.

This Journal contains the complete program for the Seventy-Ninth Annual Meeting at Hollywood — April 26-29.

Report of Delegates to A.M.A. Denver, Dec. 2-5, 1952

The Clinical Session of the American Medical Association was held in Denver, Col., Dec. 2-5, 1952.

The three Florida delegates were present and attended every session of the House of Delegates.

After the usual preliminaries, Dr. Dwight H. Murray, Chairman of the Board of Trustees, announced that Dr. John Mastin Travis of Jacksonville, Texas, was the recipient of the award for the General Practitioner of the Year.

President Louis H. Bauer's address consisted of a report of his activities for the past six months and certain remarks relative to the distribution of doctors. He noted that rather than a shortage of doctors existing, it was a case of poor distribution. He made several recommendations: (1) that this House of Delegates urge constituent state associations to be adamant in disciplining unethical members; (2) that it urge component county societies to establish more rigid ethical requirements for membership; (3) that it urge all medical schools to give lectures on medical ethics and medical traditions; and (4) that the House of Delegates go on record as thoroughly disapproving any business arrangements between pharmacists and physicians which could in any way have the appearance of kickbacks.

There were many resolutions from the various medical associations which touched on nearly every subject of interest to physicians. The action on these resolutions can be found in the Dec. 27, 1952 issue of the Journal of the American Medical Association.

The House spent much time in an effort to work out an equitable plan for medical services to Veterans with non-service-connected disabilities. It was the opinion of the majority of the members that Veterans with non-service-connected disabilities who were able to pay were no more entitled to free hospital and medical services than other citizens. A plea was made by the Director of the Veterans Administration to leave the matter in status quo since many Veterans Administration hospitals were connected with medical schools. He stated that to disrupt their program at this time would wreck the training programs for interns and residents. The matter was left for further study.

Dr. Louis M. Orr II served as Chairman of the Reference Committee on Reports of Board of Trustees and Secretary. He conducted the affairs of the committee in such an outstanding manner that he was given a rousing cheer when he completed his report. He is to be congratulated for rendering excellent service.

The next meeting of the American Medical Association will be in New York, June 1-5, 1953. The next clinical session will be in St. Louis.

Dr. Homer L. Pearson, Jr., the author of this report, attended his last session of the House of Delegates as a delegate from Florida. He continues as a member of the Judicial Council and wishes to express appreciation to the Florida Medical Association for the privilege of serving in the House of Delegates of the American Medical Association for the past ten years. The Florida delegation enjoys the confidence and respect of the House and the addition of Dr. Reuben B. Chrisman, Jr., to the delegation will definitely add strength and character.

Respectfully submitted,
Homer L. Pearson, Jr., M.D.
Louis M. Orr II, M.D.
Herbert L. Bryans, M.D.

Graduate Medical Education

The Florida Clinical Diabetes Association will hold its first annual meeting at the Soreno Hotel in St. Petersburg on May 14-15, 1953.

Guest speakers for this meeting will be Dr. Howard Root of the Joslin Clinic, Boston, and Dr. F. B. Peck, Director, Medical Division of the Lilly Research Laboratories, Eli Lilly and Company, Indianapolis. They will deliver approximately twelve lectures, and in addition there will be papers on diabetes mellitus presented by members of the association. This meeting will be open to all members of the Florida Medical Association. Any physician not a member of the Florida Medical Association wishing to attend will have to have an application approved by a member of his nearest medical society.

The scientific papers will be presented on Thursday and Friday, May 14 and 15. A dinner meeting will be held on Thursday evening for members of the association and their guests. Friday evening at 8 p.m. there will be a meeting to which the general public will be invited. Dr. Root and Dr. Peck will address this meeting also.

Both Dr. Root and Dr. Peck are well known to the medical profession of the state for their contributions to medicine, particularly those pertaining to diabetes mellitus. They have both ap-

peared before medical groups in Florida in the past and have discussed their respective fields of interest.

The Diabetes Association is affiliating with the Department of Medicine of the Graduate School of the University of Florida and the Florida State Board of Health in presenting this program. Attendance on this meeting will permit a legitimate deduction on income tax returns.

* * *

The Twenty-First Annual Graduate Short Course will be presented the week of June 22-27, 1953, at the George Washington Hotel in Jacksonville. The subjects as given last year will be continued. This graduate instruction was designed in the beginning primarily for the general practitioner, and it is with this thought in mind that the program has been made up each year.

Three new instructors appear on the program this year. Dr. Robert E. Cooke, Assistant Professor of Pediatrics and Physiology, Yale University School of Medicine, will deliver the lectures on Pediatrics. Dr. Cooke will be the first physician from Yale University appearing on a Short Course program. Dr. Conrad G. Collins, Professor of Obstetrics and Gynecology, The Tulane University of Louisiana School of Medicine, will give the lectures on Gynecology. In the past there have been many members of the faculty from Tulane University, all of whom have given excellent service. Dr. Kenneth W. Warren, Lahey Clinic, Boston, will deliver the lectures on Surgery. Dr. Warren is an excellent lecturer and, being a Floridian, also understands some of the local problems.

It is anticipated that Dr. George S. Mirick, Associate Professor of Medicine, The Johns Hopkins University School of Medicine, will deliver the lectures on Medicine again this year and that Dr. M. Edward Davis, The Joseph Bolivar DeLee Professor of Obstetrics and Gynecology, The University of Chicago, The School of Medicine, will return to lecture on Obstetrics. Both were distinguished members of the faculty last year.

The President will deliver his annual address at the first meeting of the House of Delegates, Tuesday morning, April 28.

Florida Society of Ophthalmology and Otolaryngology Holds Midwinter Convention

The sixth midwinter convention of the Florida Society of Ophthalmology and Otolaryngology was held on Jan. 14, 1953 at the Sans Souci Hotel in Miami Beach. Meeting annually in conjunction with the Midwinter Seminar in Ophthalmology and Otolaryngology sponsored by the Department of Medicine of the Graduate School of the University of Florida, this society had an unusually large representation of its membership present this year. In addition, many distinguished guests from all over the nation were in attendance.

Dr. Joseph W. Taylor, Sr., of Tampa, President, opened the scientific session at 8:15 p.m. The two guest speakers were Dr. I. S. Tassman of Philadelphia and Dr. Victor Goodhill of Los Angeles. Dr. Tassman spoke on "Difficulties Encountered in Postoperative Cataracts," and the subject of Dr. Goodhill's address was "New Testing Technics in Pediatric Deafness."

In accordance with custom, Dr. Taylor presented a past president's key to Dr. Charles C. Grace of St. Augustine, the immediate past president of the society.

The members of these two specialty groups within the state are more and more availing themselves of the privilege of attending this yearly gathering, timed with the Seminar, where the highest type of graduate training and stimulating fellowship abound.

Preceding the meeting, the many visiting physicians and their wives were entertained at the cocktail hour in the Blue Sails Room of the hotel.

Seventh Midwinter Seminar in Ophthalmology and Otolaryngology

During the week of Jan. 12, 1953, the University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology was held at the Sans Souci Hotel in Miami Beach. Holding its annual meeting there for the seventh successive year, the Seminar attracted registrants from 30 states, the District of Columbia, Canada and Cuba, with the attendance reaching a new high of 206. Coast to coast interest in this important feature of the Florida Postgraduate Medical Education program, sponsored yearly by the Department of Medicine of the Graduate School of the University of Florida, is evident from the registration by states:

Florida, 36; Pennsylvania, 22; Ohio, 20; New York, 17; Illinois and Michigan, 9 each; Virginia, 8; Indiana and Massachusetts, 6 each; Texas, 5; Georgia, Maryland, Minnesota, Mississippi, North Carolina and Wisconsin, 4 each; California, Connecticut and South Carolina, 3 each; Alabama, Nebraska, Oregon and South Dakota, 2 each; Delaware, Kentucky, New Jersey, Oklahoma, Tennessee, Washington and West Virginia, 1 each; and the District of Columbia, 7. From Canada there were 12 registrants and from Cuba 1.

The five distinguished specialists who lectured on Ophthalmology the first three days were Dr. Walter S. Atkinson, Watertown, N. Y.; Dr. Charles E. Iliff, Baltimore; Dr. Brittain F. Payne, New York City; Dr. Lawrence T. Post, St. Louis; and Dr. I. S. Tassman, Philadelphia. The lectures on Otolaryngology were presented on the last three days by five eminent authorities in this specialty, Dr. A. C. Furstenberg, Ann Arbor, Mich.; Dr. Victor Goodhill, Los Angeles; Dr. Frank D. Lathrop, Boston; Dr. Samuel Salinger, Chicago; and Dr. Theodore E. Walsh, St. Louis.

The growing interest in the Seminar, as manifested in general by the attendance from throughout the nation and in particular by increased attendance of Florida ophthalmologists and otolaryngologists, is especially gratifying to the University officials and the individual physicians who have sponsored this meeting from year to year. They have made it from its inception an unparalleled opportunity for graduate training in a midwinter environment having special appeal. The large number of Florida physicians practicing these two specialties are more than fortunate to have this training conveniently at hand every January. and the encouraging upward trend in registration from among their number should soon exceed the steady rise for the nation as a whole.

Florida Cancer Council Annual Meeting Held

The Florida Cancer Council held its annual meeting in Jacksonville on Dec. 7, 1952. This Council is made up of two physicians representing the American Cancer Society, Florida Division, two representatives of the Florida Medical Association's Committee on Cancer Control, one representative of the American College of Surgeons, and two representatives of the Florida State Board of Health.

It was reported that the following approved tumor clinics are now in operation:

Pensacola
Tallahassee
Jacksonville
  Duval Medical Center
  St. Vincent's Hospital
Gainesville
Ocala
Orlando
Daytona Beach
Miami
  Jackson Memorial Hospital
  St. Francis Hospital, Miami Beach
West Palm Beach
Fort Lauderdale
Tampa
St. Petersburg
Lakeland

These tumor clinics are receiving financial assistance from the American Cancer Society, Florida Division, and the Florida State Board of Health. This financial assistance is used to pay the salary of the secretary or nurse in the clinics and also to meet incidental operating expenses. No fees are paid to physicians for their services in these clinics. The medical director of each clinic is a physician selected either by the hospital staff or medical society, and in either case the clinic has to have the approval of the local medical society.

At this Cancer Council session a resolution was passed to insure that the tumor clinics, or other cancer projects, are kept on the highest ethical standards. An annual approval of each tumor clinic, or cancer project, is required to obtain financial assistance from either the Florida State Board of Health or the American Cancer Society, or both. The local medical association's approval must be obtained annually for the tumor clinic, or cancer project, to be eligible to receive the financial assistance mentioned.

The Cancer Council report shows that approximately 106 persons are being aided monthly under the State Cancer Control Program. This financial assistance is for diagnostic studies, radiation therapy, or for hospitalization.

It was decided at this meeting that the annual three day seminar will not be conducted during 1953. The crossroads seminar, however, will be continued during this year. Efforts are to be made to assist local medical societies in the presentation of talks on cancer at their regular monthly medical meetings. Individual medical societies will be contacted regarding assistance in their local medical society programs, if this assistance is desired by them.

Lorenzo L. Parks, M.D., Secretary
Florida Cancer Council

Revaluation of Tumor Clinics

The Florida Cancer Council at its regular meeting in Jacksonville on Dec. 7, 1952, requested that each of the tumor clinics or cancer projects in Florida financed, in part or entirely, by the American Cancer Society and the Florida State Board of Health, submit the following information annually:

1. Name of the director of the clinic or project.
2. Names of the medical staff and their specialty.
3. Copy of the budget operated under and source of funds, names of paid personnel and salaries.
4. Statement from the hospital chief of staff, if the clinic or project is operated by a hospital, that the clinic has been formally approved by the hospital staff. Also a statement from the secretary of the county medical society each year that the clinic or project has formally been approved by the county medical society in the area in which the clinic or project is located.

The funds made available by the Florida State Board of Health and the American Cancer Society, Florida Division, for the support in part or entirely of the tumor clinic or other cancer project are given upon the condition that the clinic or project meets the requirements of the American College of Surgeons and the Florida Cancer Council. This financial assistance is alloted on an annual basis and the information requested must be submitted annually to insure continuation of funds for the support of the separate projects.

This information should be submitted for 1953 not later than March 10, 1953. All tumor clinic directors and secretaries of county medical societies are urged to comply promptly with this request.

Lorenzo L. Parks, M.D., Secretary
Florida Cancer Council
P. O. Box 210, Jacksonville, Florida

BIRTHS AND DEATHS

Births

Dr. and Mrs. Frank Chambers, Jr., of Plant City announce the birth of a daughter, Sherrie Anne, on Jan. 17, 1953.

Dr. and Mrs. Benjamin H. Sullivan of St. Petersburg announce the birth of a daughter, Elizabeth Jane, on Jan. 31, 1953.

Deaths — Members

McKinley, Frank J., Tampa	Jan. 2, 1953
Holloway, Ellias W., Tampa	Jan. 14, 1953

Deaths — Other Doctors

Holly, Julius D., Baltimore, Md.	Oct. 9, 1952
Currence, John D., New York	Oct. 20, 1952
Gardner, Otho W., Greensboro	Jan. 29, 1953
White, Russell P., Flomaton, Ala.	Recently

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bidgood, Willis D., Deland
Bindshedler, Buell, Fort Lauderdale
Birdsong, Gordon G., Brewster
Carmona, Manuel G., Hollywood
Carver, Gordon B., Hollywood
Chambers, Frank, Jr., Plant City
Crouch, Carroll M., Daytona Beach
Dorman, Fred L., Lakeland
Dormon, George, Winter Haven
Flynn, Joseph C., Daytona Beach
Frankel, Bertram J., Hollywood
Ganey, Joseph B., Bradenton
Hernandez, Francisco A., Miami
Hippensteel, Russell R., Hollywood
Holmes, Claude D., Jr., Miami
Jewett, Jim S., Coral Gables
Johnson, James K., (Col.) Miami
Jorgenson, Harvey L., Miami
Kaufman, Harry, Miami Beach
Keller, Theodore C., Miami
Lane, Martin L., Chipley
Loftis, Warren T., Jr., Brooksville
Luppold, Luther S., So. Miami
Mason, Charlotte E., Hollywood
Meaney, Richard V., Punta Gorda
Mendelson, Joel, Daytona Beach
Moersch, Robert U., Fort Lauderdale
Morgan, Morton B., Miami Beach
Morgan, Paul W., Winter Haven
Priestley, Joseph O., Miami
Rochkind, Reuben, Miami
Seltzer, Bernard B., Hollywood
Smith, Parke G., Miami
Struhl, Theodore R., Miami
Wilson, Joseph C., Fort Walton
Winter, Wallace E., Madison

STATE NEWS ITEMS

Dr. Donald P. White of Jacksonville spoke to the Jacksonville Exchange Club on the American Heart Society recently. His address followed the showing of the film, "Be Your Age," sponsored by the Society.

Dr. Andrew J. Leon of Miami Beach, entered the U. S. Army with the rank of Captain on Feb. 6, 1953.

Dr. Hubert W. Coleman of Avon Park spoke on the emotional development of the child from birth through school age at a meeting of the P.-T.A. in the high school auditorium on January 15.

Dr. James C. Lanier of Jacksonville spoke at the January meetings of the Jacksonville Beach Junior Woman's Club and the Springfield Woman's Club and Improvement Association.

The first biennial cardiovascular disease institute for nurses was held January 8-9 in Pensacola at the Pensacola Vocational School. Pensacola doctors taking part were Dr. Charles A. Patterson who spoke on "Hypertensive Heart Disease;" Dr. William P. Hixon who spoke on congestive heart failure; and Dr. Walter B. Tomlinson who gave a talk on rheumatic heart disease. Dr. William J. Overman of Warrington spoke on "What is a Heart Attack?" The institute was sponsored by the Florida State Board of Health, Florida Heart Association and the Florida Nurses Association.

Among those taking part in a Cardiovascular Disease Institute for Nurses held in February at Jackson Memorial Hospital were Drs. Robert F. Farrington, E. Sterling Nichol and Edwin P. Preston, Miami; and Drs. Victor H. Kugel and Nicholas A. Tierney, Miami Beach. The Institute was sponsored by the Florida Heart Association and the State Board of Health with the Heart Association of Greater Miami acting as host.

Dr. John A. Lauer, Jr., of Tallahassee entered military service on Jan. 19, 1953, with the rank of first lieutenant, U. S. Air Force.

Officers of the Greater Miami Eye, Ear, Nose and Throat Society for 1953 are Dr. George W. Lawson, Miami, President; Dr. Garland M. Johnson, Fort Lauderdale, First Vice President; Dr. John V. McMackin, Miami, Second Vice President; and Dr. James H. Mendel, Jr., South Miami, Secretary-Treasurer.

Dr. Philipp R. Rezek of Miami gave a series of lectures from January 26 to February 1, by invitation of the staff of the Lago Oil & Transport Company in Aruba, and the Medical Society in Curacao, Netherlands West Indies. These lectures covered the following topics: "Pathology of Unexpected, Spontaneous Death," "Pathology of Pielonephritis in Pregnancy, and Sequela," and "Conception and Limitations of Malignancy."

Dr. Frank G. Slaughter of Jacksonville for the second time has gone back into biblical history in his new book, "The Galileans," the story of Mary Magdalene. Dr. Slaughter recently was called to Hollywood, Calif., as advisor on a new biblical film and to assist in writing the script for two of his books which will soon be made into movies.

Dr. Joseph S. Stewart of Miami spoke on "Cancer" at a meeting of the Northeast Miami Woman's Club in January. Dr. Stewart represented the Dade County Medical Association.

Dr. William C. Hutchison of Miami addressed the Hialeah-Miami Springs Kiwanis Club on "Modern Advances in Medicine" recently.

Dr. William J. Creel of Eau Gallie, a member of the Board of Public Instruction of Brevard County for more than 22 years, was re-elected Board Chairman recently.

Dr. John H. Mitchell of Jacksonville has returned to his practice after attending the meeting of the A. M. A. Council on Industrial Health in Chicago.

President Robert B. McIver of Jacksonville spoke at the regular monthly meetings of the Pinellas County Medical Society in St. Petersburg on February 2, the Hillsborough County Medical Association in Tampa on February 3, and the Orange County Medical Society in Orlando on February 18.

Dr. David R. Rothrock of Miami, representing the Mental Health Society of Southeast Florida, has made addresses before the following organizations: P.-T.A. Central Beach Elementary School and Hollywood Hill Elementary School, Rotary and Kiwanis Clubs at Miami Shores Country Club and the North Dade Jewish Center in North Miami.

Dr. Irwin Perlmutter of Miami spoke on "Muscular Dystrophy" on the "Hope Unlimited" program over WQAM in December.

Dr. William V. Roberts of Sanford entered the U. S. Navy on Jan. 7, 1953.

Dr. Sherman B. Forbes of Tampa has been reappointed Consultant by the National Society for the Prevention of Blindness.

Dr. William E. Middleton of Starke was honored recently with a celebration staged by his friends throughout Bradford and surrounding counties. Thursday, January 29, was proclaimed Dr. W. E. Middleton Day in Starke. Dr. Middleton observed his seventy-sixth birthday on January 30, and has a record of 50 years of medical practice in the county. Schools were closed, and a picnic and parade were held. Principal speaker at the celebration was Dr. Turner Z. Cason of Jacksonville.

Dr. A. B. Harbison of Crescent City celebrated his ninety-fifth birthday on January 1. The entire community joined in wishing a happy birthday to the town's oldest and most outstanding citizen.

Dr. Bascom H. Palmer of Miami was presented recently with a citation for "meritorious, unselfish and outstanding work" for the blind by the Florida Council for the Blind.

Dr. Nathaniel M. Levin of Miami spoke at the second annual meeting of the Florida Laryngectomees Association at Stuart recently. Dr. Levin introduced a number of laryngectomees upon whom he had operated during the past 18 years. He explained that the operation alone was not sufficient, but that rehabilitation work afterward was a most important matter in teaching laryngectomees to speak again.

Taking part in a two-day postgraduate and refresher course for nurses on heart diseases held in Orlando were Drs. Elwyn Evans, John D. McKey, Lewis L. Kline, and Fred Mathers of Orlando; and Dr. Ruth S. Jewett of Winter Park.

Tampa physicians, Drs. Kenneth G. Gould, William C. Blake, H. Phillip Hampton, Victor H. Knight, Jr., Joseph C. Flynn and Elbert J. Soskis participated in the first biennial cardiovascular disease institute for nurses held in that city January 26-27.

Drs. Hugh A. Carithers, Turner Z. Cason, Lawrence E. Geeslin, Mason Romaine, III, Richard G. Skinner, Jr., and Daniel R. Usdin of Jacksonville took part in the first biennial Cardiovascular Disease Institute for Nurses held in that city in January.

The Medical Forum of the Pinellas County Medical Society provided material for an article by Arthur Gordon in the February McCall's Magazine. The article tells how the idea of the Forum originated, and from this beginning, Mr. Gordon narrates from the spectator's viewpoint. The article is entitled, "The Doctor Speaks Out."

Dr. Carlos P. Lamar of Miami has been named chairman of the first Committee of International Medical Affairs of the Dade County Medical Association.

Dr. Benjamin F. Barnes, who has practiced medicine in Chattahoochee for fifty years, was honored on Sunday, February 15, by residents of the area. The event was sponsored by the local Chamber of Commerce, and the day was proclaimed "Doctor Barnes Day."

Dr. Raymond B. Squires of Pensacola spoke on the "Legal Code of the State Board of Health" at a recent monthly meeting of the Woman's Auxiliary to the Escambia County Medical Society.

Dr. Rose E. P. London of Miami Beach spoke recently on advances in heart surgery before the Mount Sinai Hospital Woman's Auxiliary.

Dr. Richard F. Stover of Miami, program chairman of the Dade County Health Council, recently presented a round table discussion on the need for better care for the mentally ill at the county level at a luncheon meeting of the group.

Drs. J. Rocher Chappell, Duncan T. McEwan and Louis M. Orr, II, of Orlando spoke at a recent meeting of the Orange Memorial Hospital Woman's Association.

Dr. Jere W. Annis of Lakeland has accepted the chairmanship of the judging committee for the 1953 essay contest among high school students on the subject "Why the Private Practice of Medicine Furnishes This Country With the Finest Medical Care," according to Dr. Eugene B. Maxwell, Tampa, Chairman of the F. M. A. Committee on Public Relations. Dr. Annis is to select the members of his committee from the faculty of Florida Southern College. The essay contest began January 1 and closed March 1. Dr. Annis will announce the names of winners March 15, Dr. Maxwell said.

Dr. Tyndall P. Harris of Jacksonville spoke at a recent meeting of the Lakewood Woman's Club of that city. The program was presented by the Duval County Chapter of the American Cancer Society.

Dr. William L. Musser of Winter Park was guest speaker at the January meeting of the Orange County Woman's Auxiliary. He spoke on the mentally retarded children of our state.

Dr. Herbert L. Bryans of Pensacola has been re-elected president of the Florida State Board of Health for his twelfth term.

Dr. Robert J. Brown of Jacksonville entered military service on Nov. 19, 1952, with the rank of Lieutenant, U. S. Navy.

Medical Officers Returned

Dr. Samuel J. Alford, Jr., who entered military service on Jan. 2, 1951, was released from active duty on Jan. 1, 1953 with the rank of Captain USAF (MC). His address is 33 West Ashley St., Jacksonville.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

LOCATION DESIRED: 29 year old internist. University trained. Board qualified. Florida license. Desires location or affiliation after completing Army service in September 1953. Write 69-78, P. O. Box 1018, Jacksonville, Fla.

FOR RENT: Lincoln Road office, Miami Beach. Waiting room furnished. Reasonable. Write 69-79, P. O. Box 1018, Jacksonville, Fla.

WANTED: Internist or General Practitioner for furnished office in northeast section of Miami. Write 69-80, P. O. Box 1018, Jacksonville, Fla.

GENERAL SURGEON: 33; Board eligible. Five years training teaching hospitals. Experienced general, gynecologic, traumatic, urologic surgery. Desires associateship or group practice. Florida license. Available immediately. Write 69-81, P. O. Box 1018, Jacksonville, Fla.

SURGEON: Age 36, now located Florida. Board eligible, University trained. Florida license. Seeks opportunity private practice, or association with group or individual. Write 69-82, P. O. Box 1018, Jacksonville, Fla.

WANTED: Location or association with group or individual. Completing Army service March 1. Interested in Obstetrics and Gynecology. Prefer East Coast. Age 37. Married. Florida license. Write 69-83, P. O. Box 1018, Jacksonville, Fla.

FOR SALE: Well established general practice and fully equipped office, in progressive Florida City. Will introduce. Retiring. Terms, if desired. Write 69-84, P. O. Box 1018, Jacksonville, Fla.

GENERAL PRACTITIONER: Desires Florida location. Will also consider institutional, industrial or aviation association. Good Geriatrics experience. Have Florida license. 43 years old. Write 69-85, P. O. Box 1018, Jacksonville, Fla.

POSITION DESIRED: As General Practitioner with group or individual, preferably coastal town. Married, 28, Category IV, year of internship, year of surgery residency. Write 69-86, P. O. Box 1018, Jacksonville, Fla.

PEDIATRICIAN: 39, Board eligible, desires location, association or group. Miami. Married, family, willing to invest. Best references. Write 69-87, P. O. Box 1018, Jacksonville, Fla.

COMPONENT SOCIETY NOTES

Dade

The program of the regular February meeting of the Dade County Medical Association was conducted by the Heart Association of Greater Miami. Short talks were given on "The Cardiac Patient in Industry," "Travel Tolerance of the Cardiac Patient," and "Psychosomatic Rehabilitation of the Cardiac Patient." Speakers on the program were Drs. Scheffel H. Wright and William M. Straight of Miami, and Dr. Emil M. Isberg of Miami Beach.

Duval

At the February meeting of the Duval County Medical Society, Dr. Sidney Olansky, nationally known specialist in venereal disease research, spoke on "Clinical Interpretations of Serological Findings." Dr. Olansky is currently director of the U. S. Public Health Service Venereal Disease Laboratory at Chamblee, Ga. He was formerly director of the Venereal Disease Treatment Center at Duval Medical Center.

Franklin-Gulf

Officers of the Franklin-Gulf County Medical Society for 1953 are Drs. Photis J. Nichols, president, Apalachicola; Albert L. Ward, vice president, Port St. Joe; and Terry Bird, secretary-treasurer, Apalachicola.

Hillsborough

At the regular meeting of the Hillsborough County Medical Association on January 6 in the Hotel Floridan, Tampa, Col. Albert Paul, executive director of the Hillsborough County Civil Defense Unit, outlined medicine's place in the defense plan for the Tampa Bay Area.

Colonel Paul spoke following the fellowship and dinner hour at 6:30. The A. M. A. film "They Also Serve" was shown preceding his address. Colonel Paul was introduced by Dr. William W. Trice, Jr., moderator for the meeting. The program was arranged by Dr. Wesley W. Wilson.

At the regular meeting of the Association in February, Dr. Robert B. McIver, President of F.M.A., Jacksonville, was the guest speaker.

Jackson-Calhoun

The annual session of the Jackson-Calhoun County Medical Society was held in Marianna at the Hotel Chipola on January 22. Scientific talks were featured on the program. Dr. Robert P. Kelly, Jr., associate professor of surgery (orthopedics) at Emory University School of Medicine, Atlanta, Ga., spoke on "Injuries of the Bone and Ligaments of the Ankle." Dr. Andrew J. Kerr of the Louisiana State University School of Medicine, New Orleans spoke on "Drugs Used in the Acute Cardiac Emergencies." Following the scientific session, a dinner was held at the hotel.

Marion

At the regular January meeting of the Marion County Medical Society, guest speaker was Dr. James L. Campbell who spoke on "Some Interesting Conditions Met With in the Urinary Tract." Dr. Campbell was accompanied by Dr. Raymond J. Fitzpatrick of Orlando.

Monroe

The regular monthly meeting of the Monroe County Medical Society was held on January 8 at the Monroe General Hospital. Discussions were held of interest to the staff and administration of the hospital.

Palm Beach

A joint meeting of the Palm Beach County Medical Society and the Palm Beach County Medical Technologists Association was held on January 26 at the Southeast Florida Tuberculosis Hospital at Lantana. An interesting program was arranged by Dr. William L. Potts, Medical Director of the Southeast Florida Tuberculosis Hospital jointly with Dr. Albert V. Hardy, Director of the Department of Laboratories of the Florida State Board of Health.

Dr. Potts presented three extremely interesting and unusual cases illustrating the problems involved in non-tuberculous patients admitted to the hospital because of incidental positive bacteriology.

(Continued on page 686)

Use of Alidase® Permits Subcutaneous Administration of Fluids at Usual Intravenous Rates

operative states—Alidase circumvents the compli-ating factors of venous thrombosis and "wornout" eins which frequently make fluid administration y vein difficult and dangerous. Simplicity and ifety of Alidase make hypodermoclysis a method f choice for preoperative preparation and postoper-tive maintenance.

burns—Plasma and electrolyte solutions can be ven subcutaneously at effective rates when Alidase employed; collapsed veins or risks of thrombosis e not a problem with this method.

Addition of Alidase to the first few cubic centimeters of fluid during hypodermoclysis speeds absorption to a degree approximating that of the intravenous route. Use of highly purified hyaluronidase in this manner avoids the well-known difficulties encountered with venoclysis, saves valuable nursing time and is more comfortable to the patient.

Hechter, Dopkeen and Yudell[1] have found that the use of hyaluronidase has "markedly increased the rates of absorption and administration of hypodermoclysis with no untoward reactions." They also found that extremely small amounts of this enzyme facilitated the absorption of fluids in that greater amounts of fluids were absorbed by the patient in a given period of time and that the localized swelling following hypodermoclysis disappeared more promptly.

Similar results with Alidase were recounted by Schwartzman, Henderson and King.[2] They observed "that absorption of various types of solutions, such as saline, glucose in saline, Hartmann's solution, Ringer's solution, penicillin, streptomycin, Adrenalin, and procaine was facilitated in every case."

In toxemias of pregnancy—Urgently-needed parenteral fluids may be administered subcutaneously with the aid of Alidase, eliminating risk of thrombosis attending repeated intravenous administration of electrolyte solutions. Alidase is the highly purified Searle brand of hyaluronidase and is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

G. D. SEARLE & CO. *Research in the Service of Medicine*

1. Hechter, O.; Dopkeen, S. K., and Yudell, M. H.: The Clinical Use of Hyaluronidase in Hypodermoclysis, J. Pediat. 30:645 (June) 1947.
2. Schwartzman, J.; Henderson, A. T., and King, W. E.: Hyaluronidase in Fluid Administration: A Preliminary Report, J. Pediat. 33:267 (Sept.) 1948.

(Continued from page 684)

Dr. Sidney Olansky, director of the U. S. Public Health Service Venereal Disease Laboratory at Chamblee, Ga., presented a talk on the Problems in Clinical Interpretation of Serologic Findings.

The meeting was well attended and the hospital played host to all present with refreshments and with a conducted tour through the regional laboratory of the State Health Department.

Pinellas

An added attraction to the January Medical Forum of the Pinellas County Medical Society was a session entitled "How to Rear Your Child." Arranged by Dr. Alvin L. Mills, St. Petersburg, of the Forum Committee, it was held in a local high school auditorium. Teen age children and their parents were invited guests. All programs are transcribed by the St. Petersburg Times, co-sponsor of the Forum, for broadcast over radio station WTSP each Sunday night, following the regular Forum program on Thursday night.

The regular monthly meeting of the Society was held on February 2.

Putnam

The Putnam County Medical Society has paid 100 per cent of its state dues for 1953.

At the regular meeting of the Putnam County Medical Society in January, Dr. George H. Putnam of Gainesville spoke on "The Management of Infections of the Urinary Tract."

St. Lucie-Okeechobee-Martin

Dr. Ben Wyman, county health doctor, was the featured speaker at the January meeting of the St. Lucie-Okeechobee-Martin County Medical Society.

This Journal contains the complete program for the Seventy-Ninth Annual Meeting at Hollywood — April 26-29.

BALLAST POINT MANOR

Care of Mild Mental Cases, Senile Disorders
and Invalids
Alcoholics Treated

Aged adjudged cases will be accepted on either permanent or temporary basis.

ACCREDITED HOSPITAL FOR NEUROLOGICAL PATIENTS by
American Medical Assn.
American Hospital Assn.
Florida Hospital Assn.

5226 Nichol St.
Telephone 62-2332

DON SAVAGE
Owner and Manager

P. O. Box 10368
Tampa 9, Florida

BOOKS RECEIVED

Correlative Neuroanatomy and Functional Neurology. By Joseph J. McDonald, M.S., Sc.D., M.D., and Joseph G. Chusid, A.B., M.D. Ed. 6 Pp. 263. Price, $4.00. Los Altos, Calif., Lange Medical Publications, University Medical Publishers, 1952.

The authors dedicate this volume to the beginner in neurology. Their aim is to present in the simplest and clearest manner those features of anatomy and physiology of the nervous system which bear upon the problems of clinical neurology. The concise outline format, so favorably received in previous editions, is again employed, supplemented by additional charts, diagrams and illustrations. Appropriate revisions have been made and new material added principally in the fields of aphasia, headache, syncope and muscle testing.

Because the scope of this book has broadened considerably since the time of its original publication as "Correlative Neuroanatomy," it now bears the title of "Correlative Neuroanatomy and Functional Neurology." The publisher and co-author in former editions, Dr. Jack D. Lange, was most cooperative in initiating, editing and supervising the preparation of this well illustrated book.

Pardon My Sneeze. By Milton Millman, M.D. Pp. 217. San Diego, Calif., Frye & Smith Ltd., 1952.

In the first part of this book, written in informal popular style, the author discusses the allergic state, the allergic mechanism, nervousness and allergy, the diagnosis and treatment of allergic disease and the various aspects of food allergy, with a concluding chapter on questions and answers. Part two deals with hay fever, bronchial asthma, eczema of infants, skin allergies and miscellaneous allergies. The third part is designed to help the allergic patient and his family remove all causative allergenic agents from his environment and concludes with six chapters devoted to helpful recipes.

This monograph is intended primarily for allergic patients and the families who care for them so that they may better understand the disorder and its management. With this information they will be able to give greater assistance to the physician in correcting the disease.

S. A. Kyle — Funeral Director

MEMBER National Selected Morticians BY INVITATION

17 WEST UNION STREET
JACKSONVILLE 2, FLORIDA
Phones 5-3766 5-3767

HILL CREST SANITARIUM

FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

Thoroughly modern in architecture and construction. Eight departments — affording proper classification of patients. All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

James A. Becton, M.D., Physician-in-charge — James Keene Ward, M.D., Associate Physician

P. O. Box 2896, Woodlawn Station, Birmingham, Alabama — Phones 9-1151 and 9-1152

OBITUARIES

Robert Blessing

Dr. Robert Blessing of Fort Lauderdale succumbed to coronary disease on Oct. 29, 1952. He was 56 years of age.

Born in Rockford, Ill., on Feb. 28, 1896, Dr. Blessing was educated in his native state. He entered Northwestern University in 1913 and was awarded the Bachelor of Science degree there in 1916. Pursuing his medical training in the same institution, he received the degree of Doctor of Medicine cum laude in 1921. He was elected to Alpha Omega Alpha and Alpha Kappa Kappa. Upon completion of an internship at Cook County Hospital in Chicago, he accepted a residency at the Children's Memorial Hospital in the same city.

Since 1940, Dr. Blessing had engaged in the practice of pediatrics in Fort Lauderdale. He was a member of the Broward County Medical Society and of the Florida Medical Association, holding honorary status for the last three years. He was also a member of the American Medical Association. A member of Phi Beta Kappa, he had been a diplomate of the American Board of Pediatrics since 1934. He was an emeritus member of the American Academy of Pediatrics and a charter member of the Florida Pediatric Society. Locally, he was an honorary member of the staff of the Broward General Hospital.

On Oct. 1, 1925, Dr. Blessing was married to Katherine Chandler, who survives. Also surviving is one daughter, Mrs. Robert C. Cain.

TUCKER HOSPITAL, INC.

212 West Franklin Street

RICHMOND, VIRGINIA

A private hospital accepting for diagnosis and treatment organic neurological conditions, selected psychiatric and alcoholic cases, metabolic disturbances of an endocrine nature, individuals who are having difficulty with their personality adjustments, and children with behavior problems. Patients with general medical disorders admitted for treatment under our staff of visiting physicians.

Under the Professional Charge of

DR. HOWARD R. MASTERS,
DR. JAMES ASA SHIELD AND ASSOCIATES

Harold Eugene Winchester

Dr. Harold Eugene Winchester died at his home in Dunedin on Nov. 29, 1952, after a brief illness. He was 64 years of age.

Born in Bismarck, N. D., on Oct. 3, 1888, Dr. Winchester was graduated from the Bismarck High School in 1906, and in 1910 received the Bachelor of Science degree from Dartmouth College. He was awarded the degree of Doctor of Medicine by the Harvard Medical School in 1914. Upon completion of an internship and a residency in surgery at Boston City Hospital, he entered the private practice of medicine at Flasher and Hazeltown in North Dakota in 1917.

In December 1924, Dr. Winchester came to Florida, locating in Dunedin, where he continued the practice of his profession until two days before his death. For more than a quarter of a century he was a member of the medical staff of the Morton F. Plant Hospital in Clearwater and served as chief of staff during the war years. Locally, he was a member of the Presbyterian Church, a member and for many years a director of the Dunedin Chamber of Commerce, which he had helped to found, a charter member and a past president of the Rotary Club of Dunedin, and a charter member and commodore of the Dunedin Boat Club. Also, he was a life member of Dunedin Lodge No. 192, F. and A.M., and was a past master of Linton Lodge No. 98, F. and A.M., Linton, N. D. He was the local surgeon for the Atlantic Coast Line Railroad.

Since 1925, Dr. Winchester had been active in the Pinellas County Medical Society. He was its president in 1930 and through the years served on many committees, including the advisory committee for procurement and assignment during World War II and the companion committee for the Korean War. For 27 years he had also been a member of the Florida Medical Association. In addition, he held membership in the American Medical Association and other medical organizations.

In 1917, Dr. Winchester was married to Margaret Howell of Morristown, N. J., who survives. Also surviving are one son, Dr. Walter Henry Winchester of Dunedin, who was associated with his father in general practice, and two sisters, Mrs. N. O. Ramstad and Mrs. F. L. Conklin, both of Bismarck, N. D.

Cook County Graduate School of Medicine

POSTGRADUATE COURSES — 1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting March 16, March 30, April 13. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting June 1. Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 16, June 15. Basic Principles in General Surgery, Two Weeks, starting March 30. Gallbladder Surgery, Ten Hours, starting April 20. Surgery of Colon & Rectum, One Week, starting April 13. General Surgery One Week, starting May 4. General Surgery, Two Weeks, starting April 20. Fractures & Traumatic Surgery, Two Weeks, starting June 15.

GYNECOLOGY—Intensive Course, Two Weeks, starting March 16. Vaginal Approach to Pelvic Surgery, One Week, starting March 30.

OBSTETRICS—Intensive Course, Two Weeks, starting March 30.

PEDIATRICS—Intensive Course, Two Weeks, starting April 6. Congenital Heart Disease, Two Weeks, starting May 18.

MEDICINE—Intensive General Course, Two Weeks, starting May 4. Electrocardiography & Heart Disease, Two Weeks, starting March 16. Allergy, One Month and Six Months, by appointment.

UROLOGY—Intensive Course, Two Weeks, starting April 13. Ten-Day Practical Course in Cystoscopy starting every Two Weeks.

DERMATOLOGY—Intensive Course, Two Weeks, starting May 11.

Teaching Faculty:

Attending Staff of Cook County Hospital

Address:

Registrar, 707 South Wood Street,

Chicago 12, Illinois

Allen's Invalid Home

MILLEDGEVILLE, GA.

Established 1890
For the treatment of
NERVOUS AND MENTAL DISEASES

Grounds 600 Acres
Buildings Brick Fireproof
Comfortable Convenient
Site High and Healthful

E. W. Allen, M.D., *Department for Men*
H. D. Allen, M.D., *Department for Women*
Terms Reasonable

WOMAN'S AUXILIARY
TO THE
FLORIDA MEDICAL ASSOCIATION
OFFICERS

MRS. HERSCHEL G. COLE, President.....*Tampa*
MRS. THOMAS C. KENASTON, President-elect.....*Cocoa*
MRS. RICHARD F. STOVER, 1st Vice Pres.....*Miami*
MRS. NELSON A. MURRAY, 2nd Vice Pres.....*Jacksonville*
MRS. REAVES A. WILSON, 3rd Vice Pres.....*Sarasota*
MRS. TAYLOR W. GRIFFIN, 4th Vice Pres.....*Quincy*
MRS. ALBERT G. LOVE, IV, Recording Sec'y.....*Gainesville*
MRS. HERBERT B. LOTT, Correspd. Sec'y.....*Tampa*
MRS. SAMUEL S. LOMBARDO, Treasurer.....*Jacksonville*

COMMITTEE CHAIRMEN

MRS. CHARLES F. HENLEY, Finance.....*Jacksonville*
MRS. EDWARD F. SHAVER, Today's Health.....*Tampa*
MRS. ALVIN L. MILLS, Legislation.....*St. Petersburg*
MRS. C. RUSSELL MORGAN, JR., Public Relations....*Miami*
MRS. WILLIAM G. MERIWETHER, Reference.....*Plant City*
MRS. SHERREL D. PATTON, Civil Defense.....*Sarasota*
MRS. CARROLL V. HERRON, Projects.....*Daytona Beach*
MRS. JULIUS ALEXANDER, Program.....*Miami*
MRS. JAMES T. COOK, JR., Bulletin.....*Marianna*
MRS. GEORGE H. PUTNAM, Historian.....*Gainesville*
MRS. ANGUS D. GRACE, Parliamentarian.....*Fort Myers*
MRS. ALFONSO F. MASSARO, Revisions.....*Tampa*
MRS. JOHN E. MAINES, JR., Stu. Loan Fund....*Gainesville*
MRS. ARTHUR R. KNAUF, Medalin.....*Tampa*
MRS. CHARLES McD. HARRIS, JR., Study Group.....*W. P. Beach*
MRS. C. ROBERT DEARMAS, Auxiliary Writer for State Medical Journal.....*Daytona Beach*
MRS. EDWARD W. CULLIPHER, Stu. Nurse Recruit. *Miami*
MRS. LEFFIE M. CARLTON, JR., Hospitality.....*Tampa*

How Do We Get That Way?

Inasmuch as the nominating committee is beginning to function in preparation for the April meeting, it might be a good idea to explain the state organization in relation to the county so that the uninitiated can see how we get that way.

I would particularly like to eradicate any notion that one is independent of the other. This is important because the state auxiliary cannot function without the county. Its executive board is made up of county auxiliary members, just as the National organization is made up of state officers. This system extends throughout the nation and its efficiency is impaired only by persons, who in ignorance of the objectives, fail to fulfill obligations on a local level; or because the functions of the state and national seem too remote to bind the group in loyalty or adherence to the general established policies.

A new member auxiliary, or an "out of touch" group, might think that when a county auxiliary receives a request from the state organization it is being asked to do something which doesn't matter greatly on the local level. This is unfortunate for the directives which issue from the state organization become a directive by majority of county opinion. Each county sends its delegates to the state meeting. These make up the voting contingent who are empowered to express the thinking of their group.

When a question concerns the state and its component counties, this group determines the answer. When National presents a question affecting the states, the counties discuss the issue at a state meeting and the instructed state delegates to the national meeting express the feeling of their people. The majority opinion of the states decides the outcome of a national auxiliary issue.

So, it can be seen that we operate from a grass roots level, like a huge tree the roots of which are the counties, the trunk represents the states, the over hanging branches which is like a canopy over the organization of doctors' wives, the national.

It is obvious that indifference or neglect in any part of this organizational tree would result in damage to the whole; a withering of a certain area, obligating other parts to struggle harder to maintain life.

At this time of the year the nominating committee functions like a tap root sending deep into new ground feelers for state leadership. New body to replace the "trunk" officers who are eligible to become part of the national branch and add to its foilage.

MIAMI MEDICAL CENTER

P. L. DODGE, M.D.
Medical Director and President

1861 N. W. South River Drive
Phones 2-0243 — 9-1448

A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures — Psychotherapy, Insulin, Electroshock, Hydrotherapy, Diathermy and Physiotherapy when indicated. Adequate facilities for recreation and out-door activities. Cruising and fishing trips on hospital yacht.

Information on request
Member American Hospital Association

Inasmuch as a wholesome body is made up of efficiently operating members, it is apparent that state and national officers don't just happen. No greater compliment can be paid a doctor's wife than that of being recommended by a state-wide endorsement of other doctors' wives to represent them.

Since dignity, integrity and ability are the prerequisites of each nominee they are submitted with pride and selected with care for the job they are asked to fulfill. This is the answer to how we get that way!

Mrs. C. Robert DeArmas

TWENTY-SIXTH ANNUAL MEETING

WOMAN'S AUXILIARY

Convention Committee

Mrs. Leffie M. Carlton, Jr., *Chairman*
Mrs. Mason Trupp, *Co-Chairman*

Mrs. Richard A. Bagby — Mrs. Paul J. McCloskey
Mrs. Angus D. Grace, *Parliamentarian*

REGISTRATION

East End of the Exhibit Hall

The Registration Desk will be located at the East End of the Exhibit Hall and will be open Sunday, Monday, Tuesday, 8:30 a.m. to 5:30 p.m., and Wednesday, 8:30 a.m. to 12:30 p.m. Auxiliary members and guests will be required to register and obtain their identification badges before attending any of the functions. Doctors' wives are invited to attend all of the activities of the Auxiliary.

There is no fee for registration. Printed programs may be obtained at the Registration Desk.

Pay $2.50 for Smoker privileges at the Registration Desk and obtain your receipt tag which is to be shown at the Cabanas and Pool at 9:00 p.m. Monday and worn throughout the evening.

PROGRAM

Theme: Let's Do Something About It.

Sunday, April 26

3:00 p.m. Pre-Convention Board Meeting Hollywood Beach Hotel, Parlor 455. State officers, state chairmen, county Auxiliary presidents, members-at-large.

Mrs. Herschel G. Cole
President, Woman's Auxiliary

Monday, April 27

Hollywood Beach Hotel — Flamingo Room

9:00 a.m. General Auxiliary Session

Call to Order, Mrs. Herschel G. Cole, President
Invocation, Mrs. William G. Meriwether, Plant City
Pledge of Loyalty, Mrs. Sidney G. Kennedy, Jr., Pensacola
Welcome Greetings, Dr. Robert B. McIver, Jacksonville, President, Florida Medical Association
Greetings to Auxiliary, Mrs. Julius C. Davis, Quincy
Response, Mrs. William S. Mitchell, Orlando
Presentation of Convention Chairmen

(Continued on page 692)

• In MIAMI SANITARIUM

Medical Hospital American Plan Hotel for Patients and their families. REST, CONVALESCENCE, ACUTE and CHRONIC MEDICAL CASES. Elderly People and Invalids. ***FREE Booklet!***

Acres Tropical Grounds, Delicious Meals, Res. Physician, Grad. Nurses, Dietitian.

SUN-RAY PARK HEALTH RESORT

Mild Mental Cases, Drug and Alcoholics in Separate Building

(Continued from page 691)

Introductions, Mrs. Herschel G. Cole, President
Roll Call of Counties, Mrs. Albert G. Love, IV, Gainesville
Minutes of Twenty-Fifth Annual Meeting, Mrs. Love
Reports of State Officers
Treasurer, Mrs. Samuel S. Lombardo, Jacksonville
Corresponding Secretary, Mrs. Herbert B. Lott, Tampa
President-elect, Mrs. Thomas C. Kenaston, Cocoa
First Vice President, Mrs. Richard F. Stover, Miami
Second Vice President, Mrs. Nelson A. Murray, Jacksonville
Third Vice President, Mrs. Reaves A. Wilson, Sarasota
Fourth Vice President, Mrs. Taylor W. Griffin, Quincy
In Memoriam, Mrs. Everett S. King, Lakeland
Reports of County Auxiliary Presidents
Address of National Auxiliary President, Mrs. Ralph Eusden, Long Beach, Calif.
(Fifteen Minute Recess)
Reports of State Committee Chairmen
Finance, Mrs. Charles F. Henley, Jacksonville
Legislation, Mrs. Alvin L. Mills, St. Petersburg
Medaux, Mrs. Arthur R. Knauf, Tampa
Public Relations, Mrs. C. Russell Morgan, Jr., Miami
Reference, Mrs. William G. Meriwether, Plant City
Civil Defense, Mrs. Sherrel D. Patton, Sarasota
Today's Health, Mrs. Edward F. Shaver, Tampa
Projects, Mrs. Carroll V. Herron, Daytona Beach
Program and Doctor's Day, Mrs. Julius Alexander, Miami
Bulletin, Mrs. James T. Cook, Jr., Marianna
Student Nurse Recruitment, Mrs. Edward W. Cullipher, Miami
Revisions, Mrs. Alfonso F. Massaro, Tampa
Historian and Research and Romance of Medicine, Mrs. George H. Putnam, Gainesville
Study Group, Mrs. Charles McD. Harris, Jr., West Palm Beach
Auxiliary Writer for State Medical Journal, Mrs. C. Robert DeArmas, Daytona Beach
Student Loan Fund and Jane Todd Crawford Fund, Mrs. John E. Maines, Jr., Gainesville
American Medical Foundation, Mrs. Thomas C. Kenaston, Cocoa
President's Report, Mrs. Herschel G. Cole, Tampa
Unfinished Business
New Business
Report of Finance Chairman
Election of Delegates to 1953 National Convention
Report of Courtesy Resolutions, Mrs. John H. Cordes, Jr., St. Petersburg
Report of Registration, Mrs. Albert G. Love, IV, Gainesville
Report of Nominating Committee, Mrs. C. Robert DeArmas, Daytona Beach
Election of Officers
Installation of Officers, Mrs. Ralph Eusden
Convention Announcements, Mrs. Thomas C. Kenaston

1:00 p.m. Luncheon, Northeast Dining Rooms (A, B, C)
Guests of honor, Dr. and Mrs. Robert B. McIver, Dr. and Mrs. Frederick K. Herpel, Mrs. Ralph Eusden, Dr. and Mrs. Richard F. Stover, Mrs. Paul C. Craig, Dr. and Mrs. Thomas C. Kenaston, and Dr. C. Robert DeArmas. Special table for all past state presidents.
Address at luncheon, Mrs. Paul C. Craig, Wyomissing, Pa.

9:00 p.m. Smoker — Hollywood Beach Hotel — Cabañas and Pool

Tuesday, April 28

10:00 a.m. Post-Convention Board Meeting, Parlor 455 Mrs. Thomas C. Kenaston, presiding

7:00 p.m. Association Dinner — Main Dining Room

CONVENTION PRESS

218 WEST CHURCH STREET
JACKSONVILLE
FLORIDA

Commercial and
Publication
Printing

(Continued from page 669)

White Laboratories, Inc. — 20

GITALIGIN — which has been described as a ". . . . digitalis preparation of choice" — will be on display at Booth No. 20. White's Representatives will appreciate the opportunity to discuss with you the clinical background and therapeutic merit of this and other outstanding White's products.

E. R. Squibb & Sons — 21

New Squibb products, and new brochures of useful interest to you on products already introduced, will be featured at Booth No. 21. As in former years your Squibb representative again cordially invites you to visit the Squibb booth.

A. S. Aloe Company — 24

Medical Supply Company — 25-26

Blair's Associates — 27

Philip Morris & Co., Ltd., Inc. — 28

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

Mead Johnson & Company — 29

Mead Johnson & Company, Evansville, Indiana, Booth No. 29, will feature the change in the formulation of Dextri-Maltose, the dried carbohydrate, designed specially for use in infant formulas. In addition to Natalins, small capsules containing vitamins and minerals, designed particularly for use in pregnancy and lactation, the Vi-Sols and four Pablum Cereals will be on display. Representatives in attendance will be glad to furnish information regarding the above products.

Sandoz Pharmaceuticals — 30

Bilhuber-Knoll Corporation — 31

The written prescription bespeaks the training of the physician and his treatment of the patient. The medicinal chemicals of Bilhuber-Knoll Corp. merit your study and use in your daily practice. Bromural — Sedative-Hypnotic; Dilaudid — Analgesic-Cough Sedative; Metrazol — Analeptic-Tonic; Theocalcin — Myocardial Stimulant-Diuretic. Their "Council Accepted" drugs are on display at Booth No. 31.

(Continued on page 695)

Advertisement

From where I sit *by* Joe Marsh

A Difficult "Situation"

Did you see that "Classified Ad" last week? The one that wanted a farmhand who had to be "an expert agriculturist, sheep herder, tractor driver, conversationalist, bridge player," *plus* being "an authority on chemistry, physics, and mathematics"?

Well, Slim Thomas, who ran that ad more or less as a joke, called us up yesterday and said, "I got 23 answers and almost every one claimed they could meet all *those qualifications! That means I want to keep the man I have—'Handy' Peters.*

"He was thinking of quitting but now I've *got* to talk him into staying. Handy never pretends to be an expert, he's just a good hired hand."

From where I sit, Slim's smart to be wary of people who consider themselves to be all-around "experts." Some folks will "expert" on anything—from the way a man should practice his profession to whether he ought to drink beer or buttermilk. Personally I don't want to "classify" myself as knowing all the right answers.

Joe Marsh

Copyright, 1953, United States Brewers Foundation

BRAWNER'S SANITARIUM

ESTABLISHED 1910

SMYRNA, GEORGIA

(Suburb of Atlanta)

For the Treatment of

Psychiatric Illnesses and Problems of Addiction

Psychotherapy, Convulsive Therapy, Recreational and Occupational Therapy
Modern Facilities

Custodial Care for a Limited Number of Elderly Patients at Monthly Rate

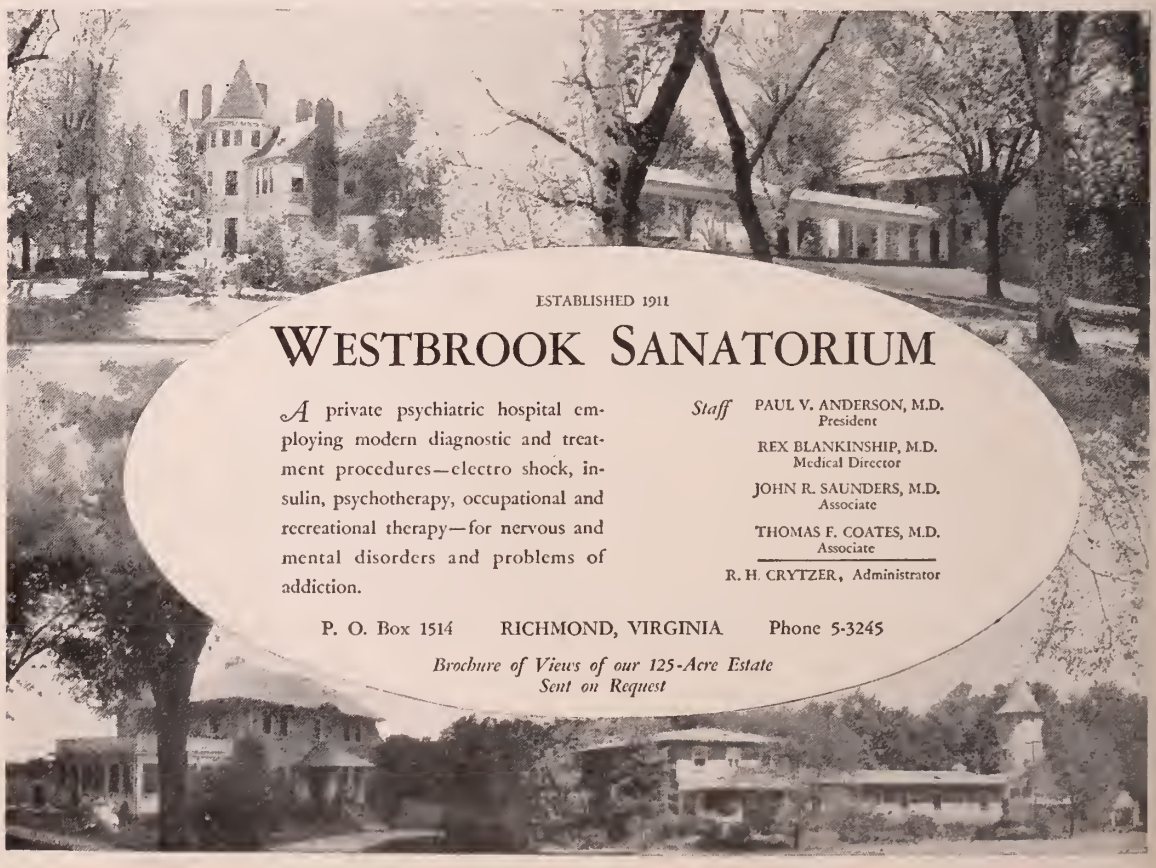
JAS. N. BRAWNER, M.D.
Medical Director

Jas. N. BRAWNER, JR., M.D.
Assistant Director and Superintendent

ALBERT F. BRAWNER, M.D.
Resident Superintendent

P. O. Box 218

Phone 5-4486



ESTABLISHED 1911

WESTBROOK SANATORIUM

A private psychiatric hospital employing modern diagnostic and treatment procedures—electro shock, insulin, psychotherapy, occupational and recreational therapy—for nervous and mental disorders and problems of addiction.

Staff
PAUL V. ANDERSON, M.D.
President
REX BLANKINSHIP, M.D.
Medical Director
JOHN R. SAUNDERS, M.D.
Associate
THOMAS F. COATES, M.D.
Associate
R. H. CRYTZER, Administrator

P. O. Box 1514 RICHMOND, VIRGINIA Phone 5-3245

Brochure of Views of our 125-Acre Estate Sent on Request

(Continued from page 693)

Eli Lilly and Company — 32

You are cordially invited to visit the Lilly exhibit in space number 32. New antibiotics, cardiac drugs, and antihistamines are featured in the display. Lilly medical service representatives will welcome your questions about these and other recent therapeutic developments.

Ayerst, McKenna & Harrison, Ltd. — 33

You are cordially invited to visit Booth 33 to see our exhibit which features "Premarin." Representatives will be happy to discuss the Ayerst line of prescription specialties with physicians attending this meeting. Literature and information relative to Ayerst products may be had at the booth. Here is an opportunity to become better acquainted with us.

Ortho Pharmaceutical Corporation — 34

ORTHO cordially invites you to Booth 34 where the well known line of obstetrical and gynecological pharmaceuticals will be on display. Particular emphasis will be placed on Ortho preparations for conception control. Ortho representatives will be on hand to offer pertinent information on their products.

BISCAYNE HOSPITAL
6339 Biscayne Blvd.
MIAMI 38, FLORIDA

Members of the Dade County Medical Association are acquainted with the high type of service rendered.

David Collins, Superintendent

Registered, American Medical Association
Phone 7-4544

Sherman Laboratories — 35

Sherman Laboratories present PROTAMIDE — A sterile colloidal solution of processed and denatured proteolytic enzyme. Published clinical studies have convincingly established Protamide's value in neuritis (post infection), herpes zoster, tabes dorsalis and chickenpox. GERICAPS — A lipotropic formula containing choline and inositol, rutin and Vitamin C, A and B-Complex. A lipotropic with "plus" factors as an aid in diabetes, coronary artery disease, atherosclerosis and faulty fat metabolism.

Mercury Medical Co. — 36

Parke, Davis and Company — 37

Hoffman-LaRoche, Inc. — 38

Chas. Pfizer & Co., Inc. — 39

Terramycin, newest of the broad-spectrum antibiotics forms a dramatic central feature of the display of Chas. Pfizer & Co., Inc., Brooklyn, New York. The newest dosage forms of Terramycin are exhibited and indications for use are described.

M & R Laboratories — 41

Your SIMILAC representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of SIMILAC in infant feeding. They have for you the latest Pediatric Research Conference Reports. Also available are current reprints of pediatric nutritional interest.

J. B. Lippincott Company — 42

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

Carnation Company — 43

You are invited to visit Booth 43 where you will see an attractive display on Carnation Evaporated Milk — "The Milk Every Doctor Knows." Some valuable information on the use of this milk for infant feeding, child feeding and general diet, will be explained and the reasons why Carnation Milk deserves consideration as your first choice for infant formulas. Interesting and valuable literature will also be available.

(Continued on page 696)

MIAMI RETREAT SANATORIUM
FOUNDED 1927
For Nervous and Mental Disorders. Alcohol and Drug Addiction
STAFF OF EIGHT NEUROPSYCHIATRISTS
New X-Ray Diagnostic Treatment Facilities
Comfortable AIR-CONDITIONED rooms, suites
79TH STREET AT MIAMI AVENUE
MIAMI 38, FLORIDA
Phone 7-1824

(Continued from page 695)

ANDERSON SURGICAL SUPPLY CO. — 44

Our display this year will consist primarily of many small items of interest to physicians. We will also have on display the Microtherm, Bloxsom Air-Lock, and our men will be anxious to explain these in detail to any interested doctor.

GENERAL ELECTRIC COMPANY X-RAY DEPT. — 45

The X-Ray Department of the General Electric Company will display a number of interesting products, including their new Cardioscribe and Model F Inductotherm. Mr. Frank R. Arrington, Jacksonville, Mr. Louie L. Clasen, Tampa, and Mr. Richard A. Steinheimer, Miami, who are in charge of the offices and supply depots in their respective cities, will be on duty at their exhibit throughout the meeting, and they extend a cordial invitation to everyone in attendance to visit the General Electric exhibit.

THE BORDEN COMPANY — 46

Spend a few pleasant minutes with Borden's at Booth 46 and refresh your memory on our Prescription Products. Meet BREMIL, conforming to the pattern of human milk; MULL-SOY, a liquid hypoallergenic soy food for your milk-allergic patients; DRYCO, with its high-protein, low-fat content for prematures and other infant feeding problems; BIOLAC, a liquid modified milk for infant feeding; BETA LACTOSE for carbohydrate supplementation; KLIM powdered whole milk; and the Special Skimmed Milks.

MERCK & CO., INC. — 47

MERCK & CO., Inc. is featuring CORTONE, HYDROCORTONE, MEPHYTON, NALLINE, and other medicinal preparations. Representatives at the Merck Booth will be glad to provide information on these and other products such as Antibiotics, NEO-ANTERGAN, URECHOLINE, and VINETHENE.

EISELE & COMPANY — 48

Eisele & Company will display their regular line of clinical thermometers, hypodermic syringes, both the regular and Interchangeable types; hypodermic needles, Eco bandages, and specialty glassware.

ENLCUTONE, INC. — 49

H. G. FISCHER & CO. — 50

Modern X-ray and Physical Therapy Equipment on display in H. G. FISCHER & CO., Booth No. 50. Your visit welcomed and appreciated. Interesting demonstration gladly given — No Obligation.

WALKER LABORATORIES, INC. — 51

HEDULIN is a new oral anti-coagulant, rapid-acting, economical and substantially safe for treatment in hypoprothrombinemia. Council Accepted HEDULIN differs chemically from oral anti-coagulants in general use. It is not a coumarin derivative and is unlikely to induce the adverse effects often attributed to this class of compounds. Clinical investigation has shown this drug to be free from cumulative effects, rapid-acting and with the favorable characteristic of returning prothrombin time to normal within 24 to 48 hours after withdrawal. HEDULIN is avaliable in uncoated tablets each containing 50 mg. of Phenindione. The initial dose should be 200 to 300 mg. of HEDULIN with a maintenance dose of 50 to 100 mg. per day in each case. After establishment of maintenance dose, prothrombin time determination is required only once in 7 to 14 days.

for Quick Action!

in the Respiratory and Circulatory Emergencies of Intravenous Barbiturate Anesthesia.

inject

COUNCIL ACCEPTED **Metrazol**

intravenously, intramuscularly, subcutaneously

In respiratory and other emergencies resulting from medullary depression during anesthesia. Ampules 1 and 3 cc., tablets, solution, powder.

Metrazol, brand of pentamethylentetrazol, Trade Mark Reg. U. S. Pat. Off., E. ilhuber, Inc., Mfr.

Bilhuber-Knoll Corp. Orange, N. J.

Southern X-Ray and Supply Co. — 53-54

The leader in research, F. Mattern Mfg. Co., brings you an important advance in X-Ray Technology: the DUOTECH CONTROL UNIT. With the DUOTECH you get consistently better results with moderately priced equipment, formerly obtainable only with the most expensive. DUOTECH Milliampere Second (MaS) Integrator gives a revolutionary concept of accuracy in radiographic quality control with the fastest possible time of exposure. The DUOTECH Simplified Technique reduces the usual 3 operational steps to 2. The Technician makes only 2 selections: MaS and PKV.

The Upjohn Company — 55

The importance of Cortisone is expanding as clinicians discover broadening uses. The Upjohn Company is justly proud of its part in the development of Cortisone and in its discovery of new production methods. It is our aim to make Cortisone available to ever increasing numbers. Competent representatives welcome your inquiries and discussion.

Pet Milk Company — 56

Specially trained representatives will be in attendance to discuss the use of Pet Milk in infant feeding, and to present many services that are time-savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

Sharp & Dohme — 57

Research data relative to oral penicillin therapy is featured at the Sharp & Dohme technical display. The exhibit endeavors to justify reliance on oral penicillin for the therapy of the majority of penicillin treatable infections, excluding fulminating diseases requiring hospitalization. A resume of pharmacological attributes of certain nasal decongestants completes the exhibit. Expertly trained personnel will be present to discuss these observations.

Abbott Laboratories — 58

Holland-Rantos Co., Inc. — 59

Jelly with diaphragm — or jelly-alone? Physicians interested in Medical Contraception are invited to discuss this timely question with Holland-Rantos convention representatives. KOROMEX DIAPHRAGMS, JELLY and CREAM, separately and in sets, will be on display. For patients' safety and confidence, the KOROMEX DIAPHRAGM and KOROMEX JELLY/or CREAM means consistently effective protection.

Ciba Pharmaceutical Products, Inc. — 60

Ciba's exhibit (Booth No. 60) features two new agents for more effective management of hypertensive disorders — REGITINE, for simple and accurate diagnosis of hypertension produced by pheochromocytoma — APRESOLINE, an agent of choice for gradual sustained lowering of blood pressure. You are invited to visit the Ciba booth for literature on APRESOLINE and REGITINE.

(Continued on page 698)

Hollywood Beach Hotel — Convention Headquarters — Program, page 658

(Continued from page 697)

McNEIL LABORATORIES, INC. — 61

Members of the Florida Medical Association are cordially invited to visit our booth No. 61, Mr. W. C. Aitken in charge. Products to be featured are Butisol Sodium, Syndrox Hydrochloride, Syntil, Cinbisal, Thyrobex, Butisol-Belladonna and Sustinex.

THE NESTLÉ COMPANY — 62

You are cordially invited to visit the Nestlé Booth No. 62 for information on Arobon, the antidiarrheal product prepared from specially processed Carob flour. Literature and information on Nestlé's milk products for infant feeding will also be available.

AMEDIC SURGICAL COMPANY — 63-64

SCHERING CORPORATION — 65

THE MEDICAL PROTECTIVE COMPANY — 66

"Know-how" in Defense and proven Protection against Loss have made The Medical Protective Company preeminent in the professional liability field for more than half a century. For authoritative answers to questions arising out of the Doctor-Patient relationship consult our representatives at Booth 66.

IVES-CAMERON COMPANY, INC. — 67

Ives-Cameron Company, Inc., cordially invite you to visit their booth, where competent representatives will be happy to discuss with you their specialties in the intestinal, arthritic and deficiency disease fields.

SCHOLTKER-THOMAS-KOCH X-RAY CO. — 68-69

U. S. VITAMIN CORPORATION — 70

See the "oil-in-water" demonstration of liposoluble vitamins A and D made completely water soluble . . . a vitamin technical achievement originated and developed by the U. S. Vitamin Corporation Research Laboratories. Three pharmaceutical firsts . . . Vi-Syneral Vitamin Drops — multivitamins in drops solution; Vi-Syneral injectable — multivitamin parenteral solution and now Vi-Aquamin — aqueous vitamins and minerals in a single capsule. We cordially invite you to our booth for detailed literature and professional samples.

THE BAKER LABORATORIES, INC. — 71

Baker's Modified Milk (Carbohydrate added) and Varamel (no Carbohydrate added) are made especially for infant feeding, from Grade A milk (U. S. Public Health Service Milk Code), which has been modified by the replacement of the milk fat with animal and vegetable oils and by the addition of Vitamins and iron.

HIGHLAND HOSPITAL, INC.

FOUNDED IN 1904

Asheville, North Carolina

AFFILIATED WITH DUKE UNIVERSITY

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a sixty-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D.,
Diplomate in Psychiatry
Medical Director

ROBT. L. CRAIG, M.D.,
Diplomate in Neurology and Psychiatry
Associate Director

J. A. Majors Company — 72

The W. B. Saunders Company, Medical Publishers, will occupy Space No. 72 at the coming convention to be held at the Hollywood Beach Hotel, April 26-29, 1953. You are invited to visit their display. Among the new books to be featured are Conn's *1953 Current Therapy;* Sheldon, Lovell & Mathews' *Clinical Allergy;* Alexander's *Treatment of Mental Disorders;* American College of Surgeons' *Surgical Forum;* Campbell's *Urology,* 2 vols.; Gross *Pediatric Surgery;* Mayo *Collected Papers;* Steinbrocker's *Pain,* and many others. Saunders will be represented by their Southern Agents, J. A. Majors Company.

Beech-Nut Packing Company — 73

Beech-Nut Cereals are now available in a 4 ounce package. This new smaller cereal box means that the babies can have a variety of cereals in a short period of time with no waste involved. *Stop* at the Beech-Nut Booth and let the Nutritionists show you this new package.

Wyeth, Inc. — 74

Wyeth will feature WYDASE® — highly purified hyaluronidase with a wide range of clinical applications, and THIOMERIN® — smooth acting, effective mercurial diuretic particularly adaptable to self administration.

Vanpelt and Brown — 75

Camel Cigarettes — 76

Medco Products Company — 77

The MEDCOLATOR Stimulator, for the stimulation of innervated muscle or muscle groups ancillary to treatment by massage, in a low volt generator that will generate plenty of your interest. Electrical muscle stimulation is a valuable form of rehabilitation therapy. Be sure to visit our booth for a personal demonstration.

The Ritter Company — 78-79

G. D. Searle and Company — 80

Surgical Equipment Company — 81

Surgical Equipment Co. of Miami will exhibit the latest type of surgical instruments and the portable direct writing electrocardiograph as well as many other new medical items. We extend a cordial invitation to all physicians to visit our booth, see our displays and demonstrations.

Parco Surgical Supplies — 82

You are cordially invited to stop by our booth, where we will have displayed some of the newer items that will be of interest. Representatives in attendance will be glad to discuss or furnish information you may desire.

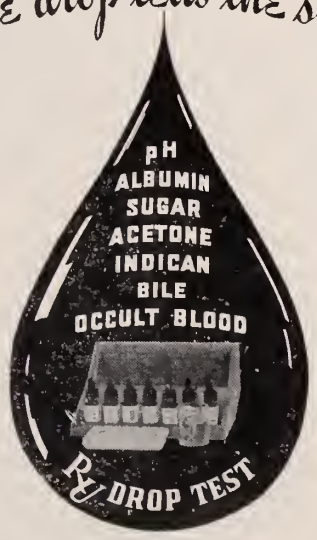
THE
MEDICAL PROTECTIVE
COMPANY
FORT WAYNE, INDIANA

PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899

specialized service
assures *"know-how"*

ST. PETERSBURG Office:
Calvin Bimer, Rep.,
240 Mateo Way, Snell Isle,
Telephone 73-289

one drop tells the story



by simply adding ONE drop of urine to ONE drop of reagent, Ru Drop Test offers a clinically accurate method . . . Unconditionally Guaranteed . . . for the complete chemical screening of all urines by One Uniform Procedure in ONE MINUTE. A comprehensive brochure on One Minute Ru Test is available at your request

ORGO PRODUCTS COMPANY
WALTERIA, CALIFORNIA

"WOW! Look what the—

MEDICAL SUPPLY MAN just brought!"

No reason to be surprised, fellows. Medical Supply Company carries more than 15,000 individual items in stock at all times. So it's no wonder you see something once in awhile you didn't know we . . . hey, wait a minute . . . you didn't think we meant the *nurse!* We were speaking of the whatever-it-is she's carrying, of course.

Seriously, though, you might well be amazed at the variety of items we keep. In fact, we'll go a step further and say that if you need supplies of any sort, kind or description, we can get them to you in a hurry! In addition, we can actually handle your inventory problems in a way that will cut down the space you need for storage and reduce your working capital, too!

There's no doubt about it! When you need supplies, equipment or repair service, it's a good idea to CALL THE MEDICAL SUPPLY MAN!

HOSPITAL, PHYSICIANS and LABORATORY SUPPLIES & EQUIPMENT

MEDICAL SUPPLY COMPANY

Essentials For Scientific Progress

MIAMI • of JACKSONVILLE • ORLANDO

230 N. E. THIRD ST.
MIAMI 32, FLA.

420 WEST MONROE ST.
JACKSONVILLE 2, FLA.

329 N. ORANGE AVE.
ORLANDO, FLA.

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
t Medical Association	Robert B. McIver, Jacksonville	Samuel M. Day, Jacksonville	Hollywood, Apr. 26-29, '53
t Medical Districts	Eugene G. Peek, Jr., Ocala	Council Chairman	
orthwest	Francis M. Watson, Marianna	Benjamin A. Wilkinson, Tallahassee	Tallahassee, 1953
ortheast	William C. Thomas, Jr., Gainesville	Eugene L. Jewett, Orlando	St. Augustine, 1953
outhwest	Emmett E. Martin, Haines City	Hugh G. Reaves, Sarasota	Tampa, 1953
outheast	Erasmus B. Hardee, Vero Beach	Donald W. Smith, Miami	West Palm Beach, 1953
a Specialty Societies			
ny of General Practice	Edward F. Shaver, Tampa	Frank T. Linz, Tampa	Hollywood, Apr. 26, '53
Society	Nelson Zivitz, Miami Beach	Solomon D. Klotz, Orlando	" "
esiologists, Soc. of	John T. Stage, Jacksonville	Breckenridge W. Wing, Orlando	" "
er, Am. Coll. Chest Phys.	Alexander Libow, Miami Beach	DeWitt C. Daughtry, Miami	" "
and Syph., Soc. of	Lewis Capland, Miami Beach	Morris Waisman, Tampa	" "
n Officers' Society	George W. Edwards, II, Orlando	Lorenzo L. Parks, Jacksonville	" "
rial & Railway Surgeons	John H. Mitchell, Jacksonville	William H. Chapman, Jacksonville	" "
logy & Psychiatry	W. Tracy Haverfield, Miami	Roger E. Phillips, Orlando	" "
d Gynec. Society	Dorothy D. Brame, Orlando	J. Champneys Taylor, Jacksonville	" "
al. & Otol., Soc. of	Joseph W. Taylor, Sr., Tampa	Carl S. McLemore, Orlando	" "
edic Society	Arthur H. Weiland, Coral Gables	Edward W. Cullipher, Miami	" "
logists, Society of	Robert J. Poppiti, Miami Beach	Alfred E. Cronkite, Fort Lauderdale	" "
ric Society	Charlotte C. Maguire, Orlando	Wesley S. Nock, Coral Gables	" "
logic Society	Alex. E. Rosenberg, Miami Bch.	George Williams, Jr., Miami	" "
logical Society	Thomas H. Lipscomb, Jacksonville	A. Judson Graves, Jacksonville	" "
zical Society	George H. Putnam, Gainesville	David W. Goddard, Daytona Beach	" "
a—			
ic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 6, '53
d Banks, Association	Donald W. Smith, Miami	Mr. J. M. Potts, Miami	Miami, May, 1953
e Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
e Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 29, '53
cer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Hollywood, Apr. 26, '53
tal Society, State	W. G. McLeod, D.D.S., Pensacola	Coleman Brown, D.D.S., Tampa	St. Petersburg, Apr. 20-23, '53
rt Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
pital Association	Mr. T. F. Little, Daytona Beach	Mr. Tracy B. Hare, Miami	Miami, Nov. '53
lical Examining Board	Ralph B. Spires, DeFuniak Springs	Homer L. Pearson, Jr., Miami	Jacksonville, June 28-30, '53
lical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 22-27, '53
ses Association, State	Mrs. Mary Livingston, W. P. Beach	Mrs. Idalyn Lawthon, Tampa	Tampa, Nov. '53
rmaceutical Association, State	Mr. Clyde Morris, Daytona Beach	Mr. R. Q. Richards, Ft. Myers	St. Petersburg, May, '53
lic Health Association	Mr. Angus Laird, Tallahassee	Mr. Fred B. Ragland, Jacksonville	Tampa, 1953
erculosis & Health Assn.	Leffie M. Carlton, Jr., Tampa	Mrs. L. C. Conant, Fort Myers	Jacksonville, May 14-15, '53
nan's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	Hollywood, Apr. 26-28, '53
can Medical Association	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	New York, June 1-5, '53
M.A. Clinical Session	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	St. Louis, Dec. '53
ern Medical Association	Walter C. Jones, Miami	Mr. C. P. Loranz, Birmingham	Atlanta, 1953
ma Medical Association	B. W. McNease, Fayette	Douglas L. Cannon, Montgomery	Birmingham, Apr. 16-18, '53
ia, Medical Assn. of	C. F. Holton, Savannah	Mr. Sid Wrightsman, Atlanta	Savannah, May 10-13, '53
Hospital Conference	Mr. Norman Losh, Orlando	Mr. D. O. McClusky, Tuscal'sa, Ala.	New Orleans, April 8-10, '53
eastern Allergy Assn.	Clarence Thomas, Nashville, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Nashville, May 15-16, '53
eastern, Am. Urological Assn.	William Miner, Covington, Ky.	Sidney Smith, Raleigh, N. C.	Havana, Cuba, Mar. 26-29, '53
eastern Surgical Congress	H. L. Claud, Washington, D. C.	B. T. Beasley, Atlanta	Louisville, Mar. 9-12, '53
Coast Clinical Society	Hays Zieman, Mobile, Ala.	William Atkinson, Mobile, Ala	Mobile, Oct., '53

THE SEVENTY-NINTH ANNUAL CONVENTION

of the

FLORIDA MEDICAL ASSOCIATION

HOLLYWOOD BEACH HOTEL APRIL 26-29, 1953

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS TOTAL	MEMBERS PAID	COUNCILOR
A	Bay	Harold E. Wager, M.D. Box 984 Panama City	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	1st Tuesday 7:30 P.M.	24	3	
	Escambia *Santa Rosa*	Alvin L. Stebbins, M.D. 621 N. O St. Pensacola	Paul F. Baranco, M.D. 608 Blount Bldg. Pensacola	2nd Tuesday 8:00 P.M.	85	49	
	Franklin-Gulf	Photis J. Nichols, M.D. Apalachicola	Terry Bird, M.D. Apalachicola	Last Wednesday except Dec. & July	7	6	A-1-54 Francis M. Watson, M.D. Marianna
	Jackson-Calhoun	Grayson C. Snyder, M.D. Floyd Bldg. Blountstown	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	16	15	
	Walton Okaloosa	Edgar H. Myers, M.D. DeFuniak Springs	William D. Cawthon, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	17	16	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		6	5	
B	Columbia **Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	10	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	T. Bert Fletcher, Jr., M.D. 516 N. Adams St. Tallahassee	Quarterly 7:30 P.M.	58	9	
	Suwannee	Hiram B. Curry, M.D. Jasper	Edward G. Haskell, Jr., M.D. Branford	1st Saturday 9:30 A.M.	8	3	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		4	3	
	Taylor **Dixie, Lafayette*	Mark E. Adams, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	4	1	243
C	Alachua **Bradford, Gilchrist, Union*	F. Emory Bell, M.D. Box 113 Gainesville	Winston L. Summerlin, M.D. 111 S. W. 3rd St. Gainesville	2nd Tuesday 8:00 P.M.	46	8	
	Duval **Clay*	W. W. Rogers, M.D. 962 Main St. Jacksonville	John T. Stage, M.D. 2033 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	248	37	
	Marion **Levy*	Eugene G. Peek, Jr., M.D. Box 248 Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	27	9	B-3-54 William C. Thomas, Jr., M.D. Gainesville
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	11	3	
	Putnam	Bernard E. Kane, M.D. Box 216 Crescent City	James A. Long, Jr., M.D. 1001 Main St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
	St. Johns	John M. Canakaris, M.D. Box 295 Bunnell	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	3	
D	Brevard	Laurent L. LaRoche, M.D. 526 Brevard Ave. Cocoa	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	2nd Tuesday	22	4	
	Lake **Sumter*	John D. Bloom, M.D. Groveland	J. Basil Hall, M.D. Tavares	1st Wednesday 7:30 P.M.	26	21	
	Orange **Osceola*	G. Tayloe Gwathmey, M.D. 417 E. Robinson Ave. Orlando	Andrew W. Townes, Jr., M.D. 717 N. Magnolia Ave. Orlando	3rd Wednesday 8:00 P.M.	151	13	B-4-53 Eugene L. Jewett, M.D. Orlando
	Seminole	Wade H. Garner, M.D. Box 219 Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	16	3	
	Volusia **Flagler*	Morris B. Seltzer, M.D. 614 N. Peninsula Dr. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	82	40	653
	Hillsborough	Arthur R. Knauf, M.D. 706 Franklin St. Tampa	Julien C. Pate, Jr., M.D. 1105 First Nat. Bk. Bldg. Tampa	1st Tuesday 8:00 P.M.	175	120	
	Manatee	William D. Sugg, M.D. Bradenton Bank Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	19	11	
	Pasco-Hernando-Citrus	Karl T. Humes, M.D. Box 157 Bushnell	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	18	14	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Pinellas	Everett M. Harrison, M.D. 1601 N. Ft. Harrison Ave. Clearwater	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Mon. Even Mo. 1st Fri. Odd Mo. 6:00 P.M.	192	168	
	Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	Melvin M. Simmons, M.D. 816 Florasota Gardens Sarasota	2nd Tuesday 8:30 P.M.	44	8	
	DeSoto-Hardee-Highlands-Glades	Wesley S. Pyatt, M.D. Bowling Green	Merle C. Kayton, M.D. Wauchula	2nd Tuesday 8:00 P.M.	25	17	
	Lee-Charlotte-Collier-Hendry	Ernest Bostelman, M.D. 201 Pythian Bldg. Fort Myers	Harry Fagan, Jr., M.D. 310 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	28	26	C-6-54 Emmett E. Martin, M.D. Haines City
	Polk	Jere W. Annis, M.D. Box 1021 Lakeland	James T. Shelden, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	95	69	596
D	Indian River	John P. Gifford, M.D. 1625 Osceola Blvd. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	6	5	
	Palm Beach	Graham W. King, Jr., M.D. Box 505 Delray Beach	David A. Newman, M.D. 175 Bradley Pl. Palm Beach	3rd Monday 8:00 P.M.	120	80	D-7-54 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	John T. McDermid, M.D. 337 N. 4th St. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	15	8	
	Broward	Claus A. Peterson, M.D. 312 Blount Bldg. Ft. Lauderdale	James M. Weaver, M.D. Box 4084 Ft. Lauderdale	4th Tuesday 8:00 P.M.	93	65	
	Dade	Ralph W. Jack, M.D. 1700 Biscayne Blvd. Miami	Walter W. Sackett, Jr., M.D. 2500 Coral Way Miami	1st Tuesday 8:30 P.M.	619	275	D-8-53 Donald W. Smith, M.D. Miami
	Monroe	Joseph L. G. Lester, Jr., M.D. 422 Fleming St. Key West	Allen S. Shepard, M.D. 638 United St. Key West	2nd Thursday 8:00 P.M.	15	3	868

Are You

CONSIDERING THE PURCHASE OF NEW EQUIPMENT?

We can equip your office complete —

Reception Room Furniture
Consultation Room Furniture
Examining and Treatment Furniture
X-Ray Equipment
Short Wave Diathermy
Scientific Equipment
Diagnostic Instruments
Laboratory Supplies
Surgical Instruments
Dressings, Ampoules, etc.

See our Representative in your area, or Visit our Store

Large Displays to Select from

MEMBER

AMERICAN SURGICAL TRADE ASSOCIATION — A.S.T.A. — Quality and Service

Anderson Surgical Supply Co.

Established 1916

Telephone 5-2560
40-42 W. DUVAL STREET
P. O. Box 1799
JACKSONVILLE, 1, FLORIDA

Telephone M-8504
1101-1105 TAMPA STREET
P. O. Box 1228
TAMPA 1, FLORIDA

Telephone 7-4589
21 3rd STREET N.
ST. PETERSBURG, FLORIDA

NEW YORK ACADEMY OF 2
MEDICINE
2 E 103RD ST
NEW YORK N Y 29 J C-E

a strong start...

Strong muscle development and excellent tissue turgor characterize the *sturdy growth* of babies fed Olac®, Mead's powdered formula.

Olac supplies milk protein in exceptionally generous amounts. Its fat, a single highly refined vegetable oil, is well tolerated and easily assimilated. Dextri-Maltose, supplementing the lactose of the milk, meets energy needs and spares protein. Vitamin A and D supplements are also included in the formula.

Olac is easily mixed with warm water—1 measure to each 2 ounces water makes a formula supplying 20 calories per fluid ounce.

Olac is ideal also for supplementary and complementary feedings of breast-fed babies.

for both full term and premature infants

Olac

MEAD

MEAD JOHNSON & COMPANY
Evansville 21, Ind., U.S.A.

Local representative: Roger J. McElroy, 3181 McDonald Street, Coconut Grove 33 Florida, 4-4124.

The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXIX APRIL, 1953 No. 10

APR 17 1953
LIBRARY

IN THIS ISSUE

Treatment of Comminuted Fractures with Rush Nail
Amsie H. Lisenby

Pott's Fractures and Associated Injuries
Lenox D. Baker

Early Treatment of Childhood Allergy
W. Ambrose McGee

West Florida
Three Centuries Under Four Flags
Conquest and Disease
An Editorial

OFFICIAL PUBLICATION OF THE
FLORIDA MEDICAL ASSOCIATION

unusually effective in infections of the gastrointestinal tract

Chloromycetin is a notably effective, w

...Chloromycetin®

is indisputably the drug of choice in typhoid fever and is considered by many to be useful in other salmonelloses

outstanding in acute Shigella dysentery, CHLOROMYCETIN permits immediate treatment regardless of dehydration and provides rapid relief.

exceptionally well tolerated, CHLOROMYCETIN (chloramphenicol, Parke-Davis) is noted for the infrequent occurrence of even mild gastrointestinal side effects, an important consideration in treating infections of the gastrointestinal tract. Although serious blood disorders following its use are rare, it is a potent therapeutic agent, and should not be used indiscriminately or for minor infections — and, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

tolerated, broad spectrum antibiotic

MEDICAMENTA VERA PD & CO.

Parke, Davis & Company
DETROIT, MICHIGAN

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

Volume XXXIX APRIL, 1953 No. 10

CONTENTS

SCIENTIFIC ARTICLES

The Treatment of Badly Comminuted Fractures with the Rush Nail, Amsie H. Lisenby, M.D. 727

Otitis Externa, William H. Turnley, M.D. 729

Pott's Fractures and Associated Injuries, Lenox D. Baker, M.D. 732

A Phase of Postpartum Bleeding with Case Reports, Merritt R. Clements, M.D. 739

The Importance of Early Treatment of Childhood Allergy in Modifying and Preventing Adult Allergic Disorders, W. Ambrose McGee, M.D. 741

ABSTRACTS OF MEDICAL ARTICLES

Drs. Frederick D. Droege, Peritz Scheinberg, Elwyn Evans, and Thomas M. Irwin 744

EDITORIALS AND COMMENTARIES

West Florida, Three Centuries Under Four Flags, Conquest and Disease 749

The Doctor Looks Ahead 765

Straws in the Wind 765

The Bricker Resolution 766

American Medical Education Foundation Plans for 1953 Campaign 767

Articles Concerning Stress and the Adaptive Hormones 767

Graduate Medical Education 768

GENERAL FEATURES

Officers and Committees 746

From Our President 748

Births and Deaths 768

New Members 769

State News Items 769

Wanted — For Sale 773

Component Society Notes 773

Books Received 774

Woman's Auxiliary 776

Medical Licenses Granted 777

Schedule of Meetings 785

List of County Societies, Presidents and Secretaries 786

This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

E. R. SQUIBB & SONS 745 FIFTH AVENUE, NEW YORK 22, NEW YORK

Dear Doctor:

Usually Inadequate

℞

Tolserol Tabs. 0.5 gram

Disp. #100

Sig: One tablet 3 to 5 ~~times~~ a day. Take after meals or with 1/3 glass of milk.

This prescription is typical of many written for Tolserol Tablets*, as seen in a recent prescription survey.

Although some patients will respond to such low dosage, much better results can be obtained by following the recommended dosage: 1 to 3 grams, 3 to 5 times per day.

In accordance with this recommendation, the first dosage schedule for a patient could be:

Better

℞

Tolserol Tabs. 0.5 gram

Disp. #100

~~Sig:~~ Two tablets 3 to 5 times a day. Take after meals or with 1/3 glass of milk.

Complete information on the use of Tolserol in muscle spasm of rheumatic disorders, neurologic disorders, and acute alcoholism is available from your Squibb Professional Service Representative.

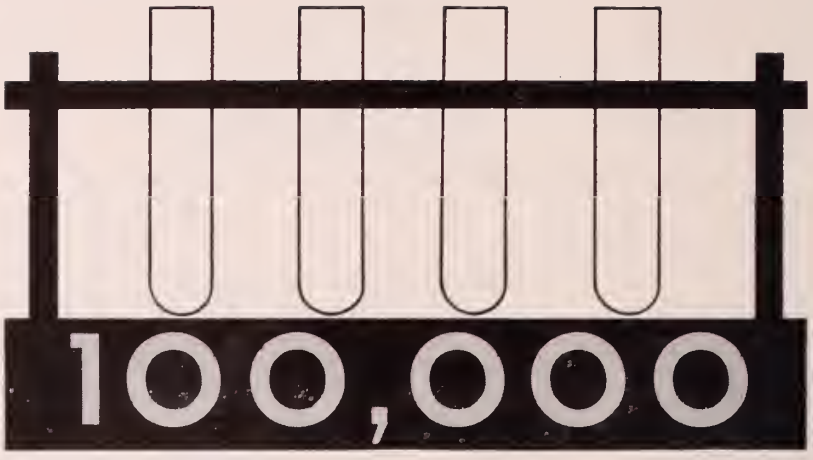
Sincerely yours,

L. H. Ashe

L. H. Ashe, Manager
Professional Service Dept.

'TOLSEROL' IS A REGISTERED TRADEMARK

*Squibb 'Mephenesin'



diabetes detection centers!

"The ideal detection center is the office of the family physician."[1]

Increasing experience in diabetes case-finding indicates that intermittent surveys and mass screening drives, although useful, have certain limitations. Getting and others,[2] in evaluating a community detection campaign (well publicized in the area), report that only 59% of persons accepting the free testing materials actually performed the test. Only 24% of those with positive results sought medical advice.

To find the estimated one million unknown diabetics[3] and place them under needed medical care, the indispensable factor for success is the activity of the individual physician.

1. Blotner, H., and Marble, A.: New England J. Med. *245*:567 (Oct. 11) 1951.
2. Getting, V. A., and others: Diabetes *1*:194, 1952.
3. Wilkerson, H. L. C., and Krall, L. P.: J.A.M.A. *135*:209 (Sept. 27) 1947.

DIABETES DETECTION IN DAILY PRACTICE — a nationwide poll

To assist in the compilation of nationwide data on diabetes, gained through the experiences of private practitioners, Ames Company recently mailed a questionnaire to the medical profession. Your reply will become a vital part of a statistical study to be published on the results of this questionnaire.

AMES
COMPANY, INC.

Elkhart, Indiana Ames Company of Canada, Ltd., Toronto

makers of CLINITEST® Reagent Tablets for detection of urine-sugar

Upjohn

less-antigenic penicillin:

Cer-O-Cillin

Trademark Reg. U. S. Pat. Off.

POTASSIUM

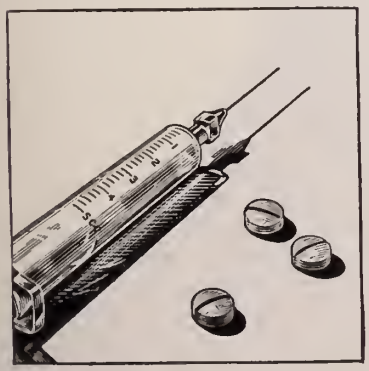
ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

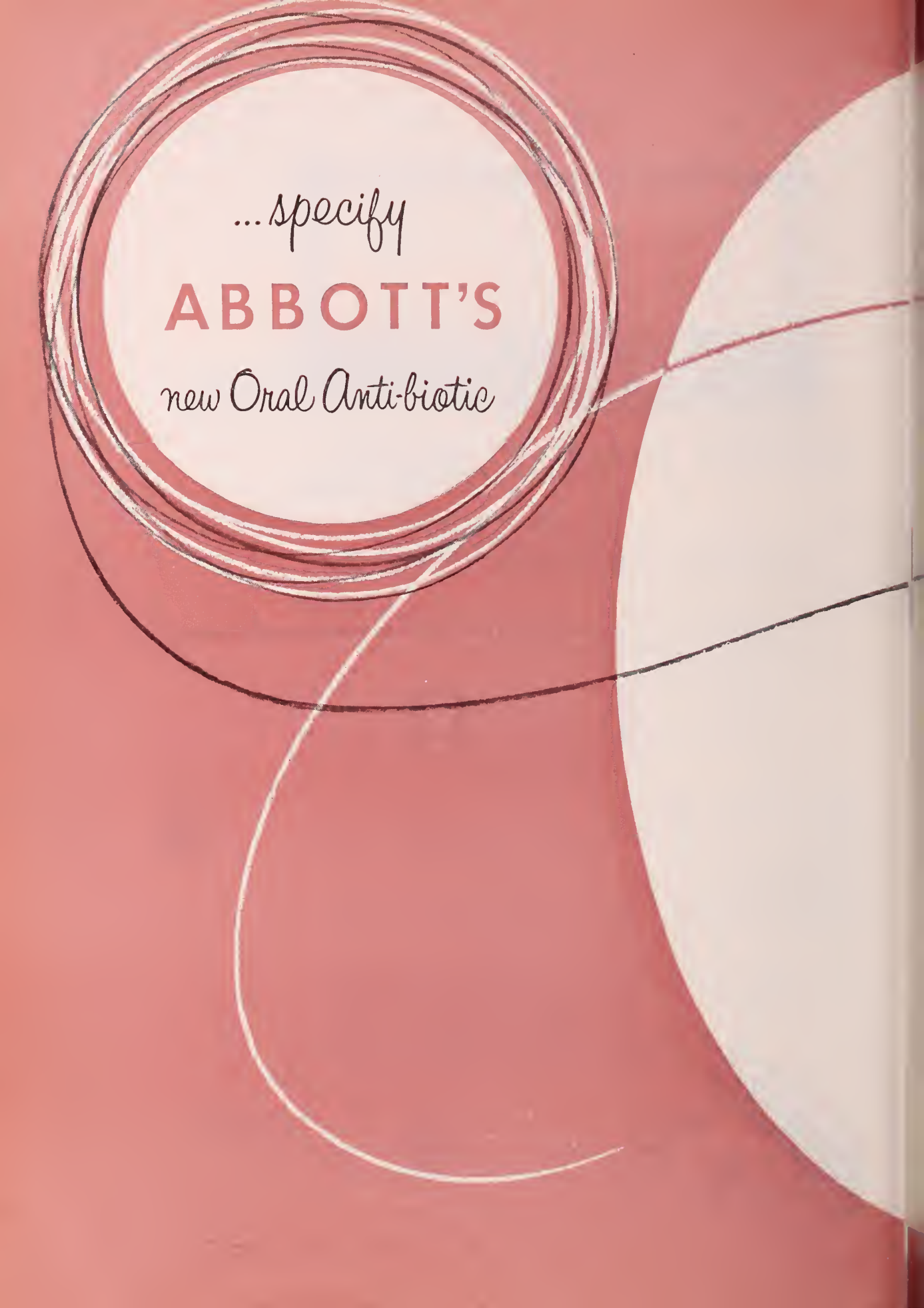
Available as:

Sterile vials containing 200,000 units Crystalline Penicillin O Potassium

Bottles of 12 buffered tablets, each containing 100,000 units Crystalline Penicillin O Potassium

The Upjohn Company, Kalamazoo, Michigan




...specify
ABBOTT'S
new Oral Anti-biotic

E *specially effective against gram-positive organisms resistant to other antibiotics.*

L *ow toxicity; reported side effects infrequent.*

S *pecial "high-blood-level" coating.*
ERYTHROCIN, *0.1-Gm. (100-mg.) Tablets, bottle of 25.*

ERYTHROCIN

TRADE MARK

(Erythromycin, Abbott)

INDICATIONS Pharyngitis, tonsillitis, scarlet fever, erysipelas, pneumococcic pneumonia, osteomyelitis, pyoderma. *Also other infections caused by organisms* susceptible to its action, including staphylococci, streptococci and pneumococci.

DOSAGE Total daily dose of 0.8 to 2 Gm., depending on severity of the infection. A total daily dose of 0.6 Gm. is often adequate in the treatment of pneumococcic pneumonia. *For the average adult* the initial dose is 0.2 Gm. to be followed by doses of 0.1 or 0.2 Gm. followed by doses in the same range every four to six hours. *For severely ill patients* doses up to 0.5 Gm. may be repeated at six-hour intervals if necessary. Satisfactory clinical response should appear in 24 to 48 hours if the causative organism is susceptible to ERYTHROCIN. Continue for 48 hours after temperature returns to normal.

Abbott

1. McGuire et al. (1952), J. Antibiotics & Chemo., 2:281, June.
2. Heilman et al. (1952), Proc. Staff Meet. Mayo Clin., 27:385, July 16.
3. Haight and Finland (1952), New Eng. J. Med., 247:227, Aug. 14.

50 YEARS AGO

℞ "Two parts of milk to one of water fulfills most of the essential conditions (for infant feeding) if 1 and 2/5 percent of fat = about 2 and 4/5 percent of 50 percent cream – that is, some 15 drops to the ounce – and 3 and 1/2 percent of sugar or about 18 grains to the ounce are added." *

TODAY

℞ One part Baker's Modified Milk
One part water

Boker's Madified Milk is mode from Grade A Milk, (U. S. Public Health Service Milk Cade) which has been modified by replacement of the milk fat with onimol and vegetable oils and by the additian of carbohydrates, vitamins and iron.

BAKER'S MODIFIED MILK SIMPLIFIES INFANT FEEDING

*Cheodle—*Artificiol Feeding and Food Disorders of Infants,* Sixth Edition, (1906)

BAKER'S MODIFIED MILK

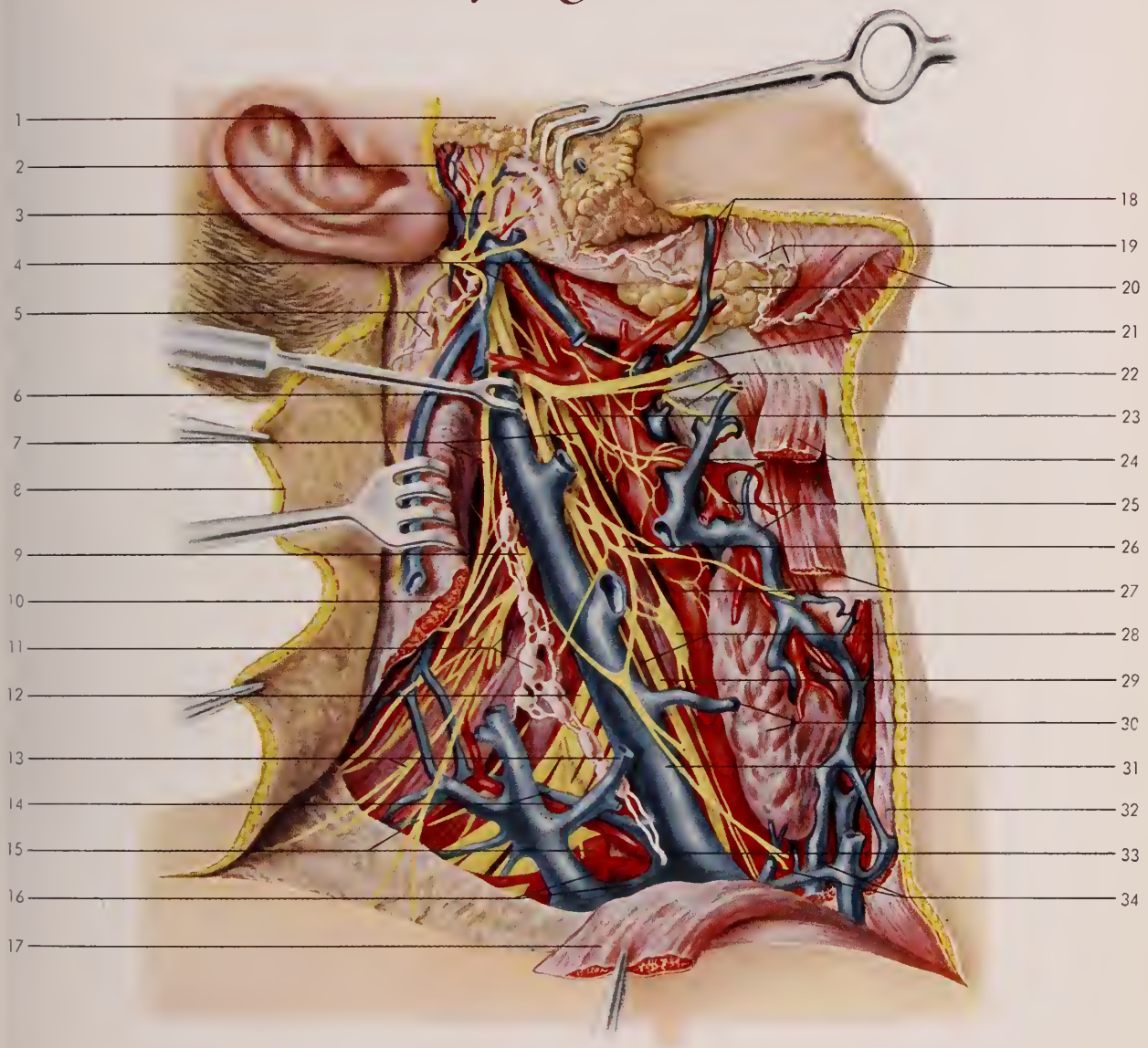
THE BAKER LABORATORIES INC.

Moin Office: Cleveland, Ohio
Plant: Eost Troy, Wiscansin

Division Offices: Atlanta, Dallos, Denver, Greensboro, N. C., Los Angeles, Son Francisca, Seottle

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

Anatomy *of the* Neck



1. Parotid gland
2. Superficial temporal artery & vein
3. Temporal branch of facial nerve
4. External carotid artery & posterior facial vein
5. Superficial cervical lymph nodes
6. External jugular vein
7. Accessory nerve & internal carotid artery
8. Platysma muscle
9. Fourth cervical nerve
10. Superior position of sternocleidomastoid muscle
11. Deep cervical lymph nodes
12. Fifth cervical nerve
13. Posterior supraclavicular nerve & anterior jugular vein
14. Superficial cervical artery & vein
15. Middle supraclavicular nerve & subclavian artery
16. Transverse scapular artery & vein
17. Inferior position of sternocleidomastoid muscle
18. External maxillary artery & anterior facial vein
19. Submaxillary lymph nodes & digastric muscle
20. Submaxillary gland & mylohyoid muscle
21. Submental lymph nodes & hypoglossal nerve
22. Superior laryngeal artery & nerve
23. Superior cervical ganglion
24. Superior laryngeal vein & omohyoid muscle
25. Superior thyroid artery & vein
26. Ansa hypoglossi
27. Common carotid artery & sternothyroid muscle
28. Middle cervical ganglion & phrenic nerve
29. Vagus nerve
30. Thyroid gland & middle thyroid vein
31. Internal jugular vein
32. Sternohyoid muscle
33. Jugular lymphatic trunk
34. Inferior thyroid veins

This is one of a series of paintings for Lederle by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.

Lederle

Aureomycin

HYDROCHLORIDE CRYSTALLINE

is valuable in
Infections of the Neck
and is especially
useful where surgery
is indicated

Literature available on request

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.

Scene from "Oliver Twist"

CHARLES DICKENS
1812-1870

Psychoneurotic Men of Genius

Charles Dickens, the renowned British novelist, was subject to cyclic moods of pronounced depression characterized by intense nervous irritability and by the shedding of tears all day long. He was exceedingly sensitive to his own experiences as well as to the suffering of others.

In the great majority of psychoneurotics, there is no serious mental illness, but merely an emotional imbalance which often can be greatly improved by proper psychotherapeutic and sedative management. In the treatment of psychoneurosis, particularly agitated, depressed and anxiety states, Mebaral is preferred by many because it combines a high degree of sedative effectiveness – producing emotional stability – with a relative freedom from side effects such as languor and drowsiness. Patients usually become calmer, more cheerful and better adjusted to their surroundings without clouding of mental faculties.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Average sedative dose:
Adults, 32 mg. to 0.1 Gm. (½ to 1½ grains) three or four times daily;
children, 16 to 32 mg. (¼ to ½ grain) three or four times daily.

Supplied in tablets of 32 mg., 0.1 Gm. and 0.2 Gm.

Mebaral®

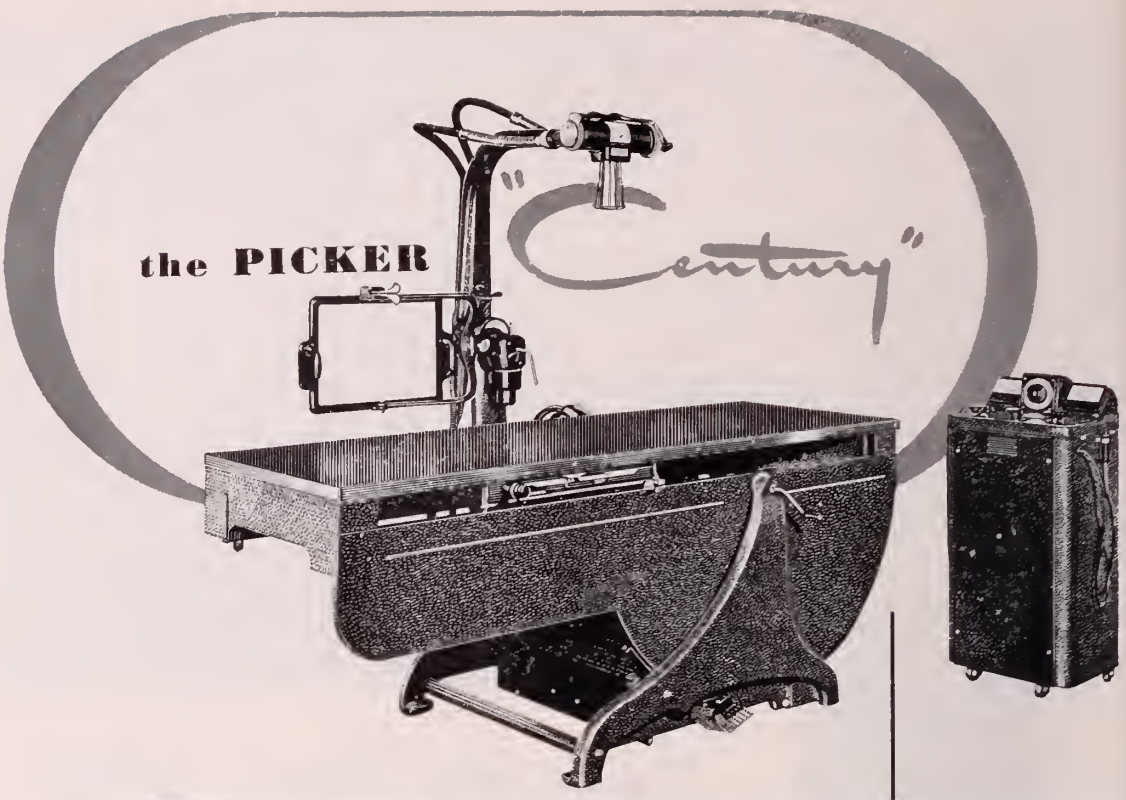
tasteless daytime sedative

EFFECTIVE ANTIEPILEPTIC

Winthrop-Stearns INC. New York 18, N. Y. • Windsor, Ont.

Mebaral, trademark reg. U. S. & Canada, brand of mephobarbital

VOLUME XXXIV
NUMBER 10



it's so *easy to use* ... the automatic "Century" Control *really* monitors operation; relieves you of technical worries.

it's so *dependable* ... identical "Century" settings produce identical results time after time — yesterday, today, tomorrow.

it's so *trouble-free* ... "Century" stamina has been amply proven in the experience of thousands and thousands of users the world over.

it's so *handsome* ... looks as distinguished as it is. Owners are *proud* of their "Centurys".

Definitely the *fine* x-ray unit in the moderate price class ... and so widely esteemed that there are more Picker "Century" 100 ma units actively in use than any other similar apparatus.

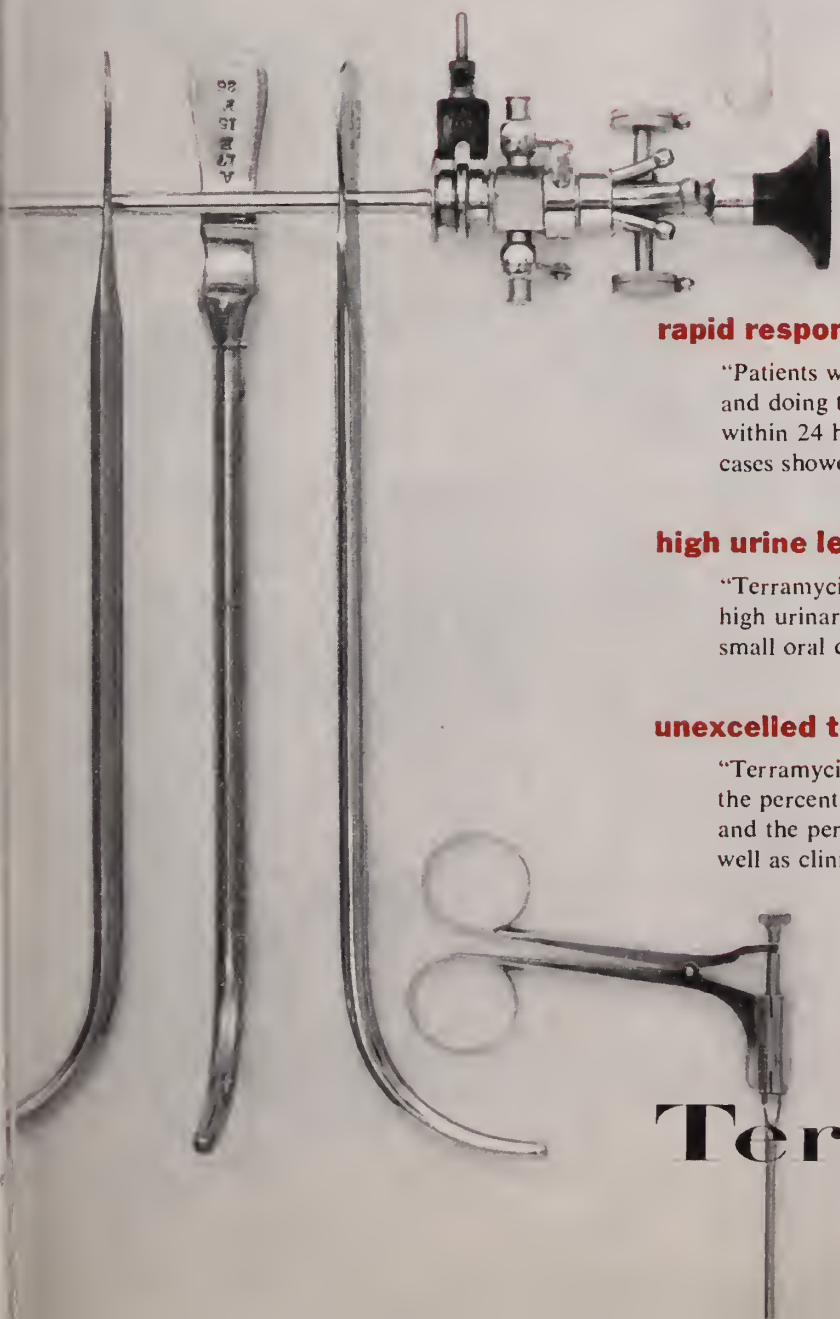
Picker x-ray

PICKER X-RAY CORPORATION
25 So. Broadway • White Plains, N. Y.

MIAMI 35, FLA., 2759 Coral Way

JACKSONVILLE, FLA., 1023 Mary Street

IN URINARY TRACT INFECTIONS



rapid response

"Patients with pyelitis were well and doing their usual duties within 24 hours . . ."[1] ". . . resistant cases showed remarkable response."[2]

high urine levels

"Terramycin was selected . . . in view of high urinary excretion rate following small oral doses of the antibiotic."[1]

unexcelled toleration

"Terramycin is generally well tolerated, the percentage of relapses being low and the percentage of bacteriological as well as clinical cures high."[3]

1. Canad. M. A. J. 66:151 (Feb.) 1952.
2. J. Urol. 67:762 (May) 1952.
3. Ibid. 69 315 (Feb.) 1953.

Terramycin

Brand of Oxytetracycline

Pfizer

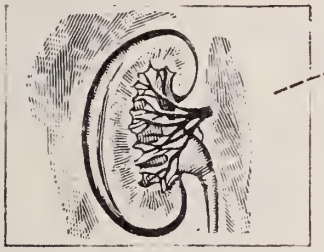
THERE MUST BE A REASON WHY

Camel leads all other brands by billions!

SO MILD, SO FLAVORFUL!

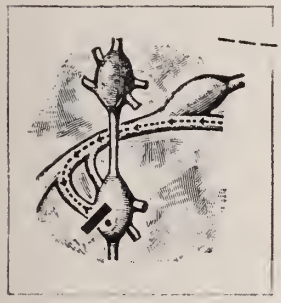
Regitine®

(phentolamine methanesulfonate Ciba), preferred in the diagnosis of pheochromocytoma, the cause of the most common form of hypertension of *known* etiology. The injection of this *adrenergic blocking agent* affords an accurate test that is relatively safe, and can be simply performed by any physician, unassisted, in his office.



three new agents in the control of hypertension

Complete information can be obtained by writing to the Medical Service Division, Ciba Pharmaceutical Products, Inc., Summit, New Jersey.



Esomid®

chloride (hexamethonium chloride Ciba), a potent oral hypotensive agent, may be particularly valuable in those patients with severe hypertension which has failed to respond to Apresoline. Esomid acts as a *ganglionic blocker,* inhibiting the transmission of impulses through all autonomic ganglia.

Apresoline®

hydrochloride (hydralazine hydrochloride Ciba), an agent of choice (for use) in the treatment of hypertension. This orally effective antihypertensive is believed to act *centrally* to produce a gradual, sustained decrease in blood pressure while increasing blood flow through the kidneys.

Ciba

. . . and then I says to him, "if you're in that much of a jam, you'd better

call the MEDICAL SUPPLY MAN!"

And that's exactly what he did, Gertrude! Almost everybody in the medical profession knows it's always a good idea to call the Medical Supply man when they need help. And there's a good reason for this!

Normally, the Medical Supply Company handles more than 15,000 individual items made by nearly 600 manufacturers. Doctors know that the best and fastest way to get the equipment and supplies they need, is to call the Medical Supply Man. They know, too, that when old equipment and instruments won't work right, Medical Supply can put them in tip-top shape again!

So, when you need help, never neglect that impulse . . . CALL THE MEDICAL SUPPLY MAN! He'll do everything he can to get you what you want, when you want it.

HOSPITAL, PHYSICIANS and LABORATORY SUPPLIES & EQUIPMENT

MEDICAL SUPPLY COMPANY

Essentials For Scientific Progress

MIAMI • of JACKSONVILLE • ORLANDO

230 N. E. THIRD ST, MIAMI 32, FLA.

420 WEST MONROE ST. JACKSONVILLE 2, FLA.

329 N. ORANGE AVE. ORLANDO, FLA.

...“truly extraordinary” results in intractable bronchial asthma

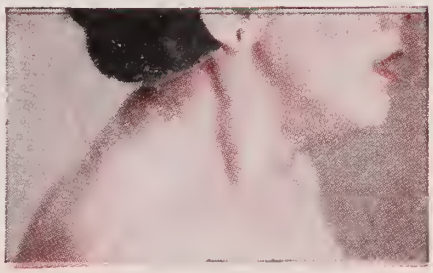
Cortone®

ACETATE

(CORTISONE ACETATE, MERCK)

In a review article on hormonal therapy,[1] complete relief of symptoms was reported in 62 per cent of 116 asthma patients. Another 24 per cent were made “quite comfortable.” Duration of relief varied widely, with remissions occasionally lasting as long as several months. The author calls these results “truly extraordinary.”

[1]Evans, R. R., and Rackemann, F. M.: *A.M.A. Arch. Int. Med.* 90:96–127, July 1952.



Before treatment. Observe typical facies and tense sternocleidomastoid.

After therapy with CORTONE. Note relaxation of accessory muscles of respiration.

All CORTONE *Tablets carry this trade-mark:* 4

CORTONE *is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone.*

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY

© Merck & Co., Inc.

This is one of a series of advertisements designed to explain the Councils' functions to you.

"Does this product have A. M. A. Council Acceptance?"

The first question many physician ask the detail man when a new product is presented.

If the detail man can answer "Yes," you know that the composition of the product has been carefully verified, that members of the Council have checked the clinical evidence, the label, the claims and agreed that the product merits your confidence. You can, of course, ask your own questions, and make your own decision about using any product. However, you save yourself a vast amount of time—and gain the benefit of an expert, fact-finding body whose work protects you and your patient. Therefore, why not use Council Acceptance as your guide?

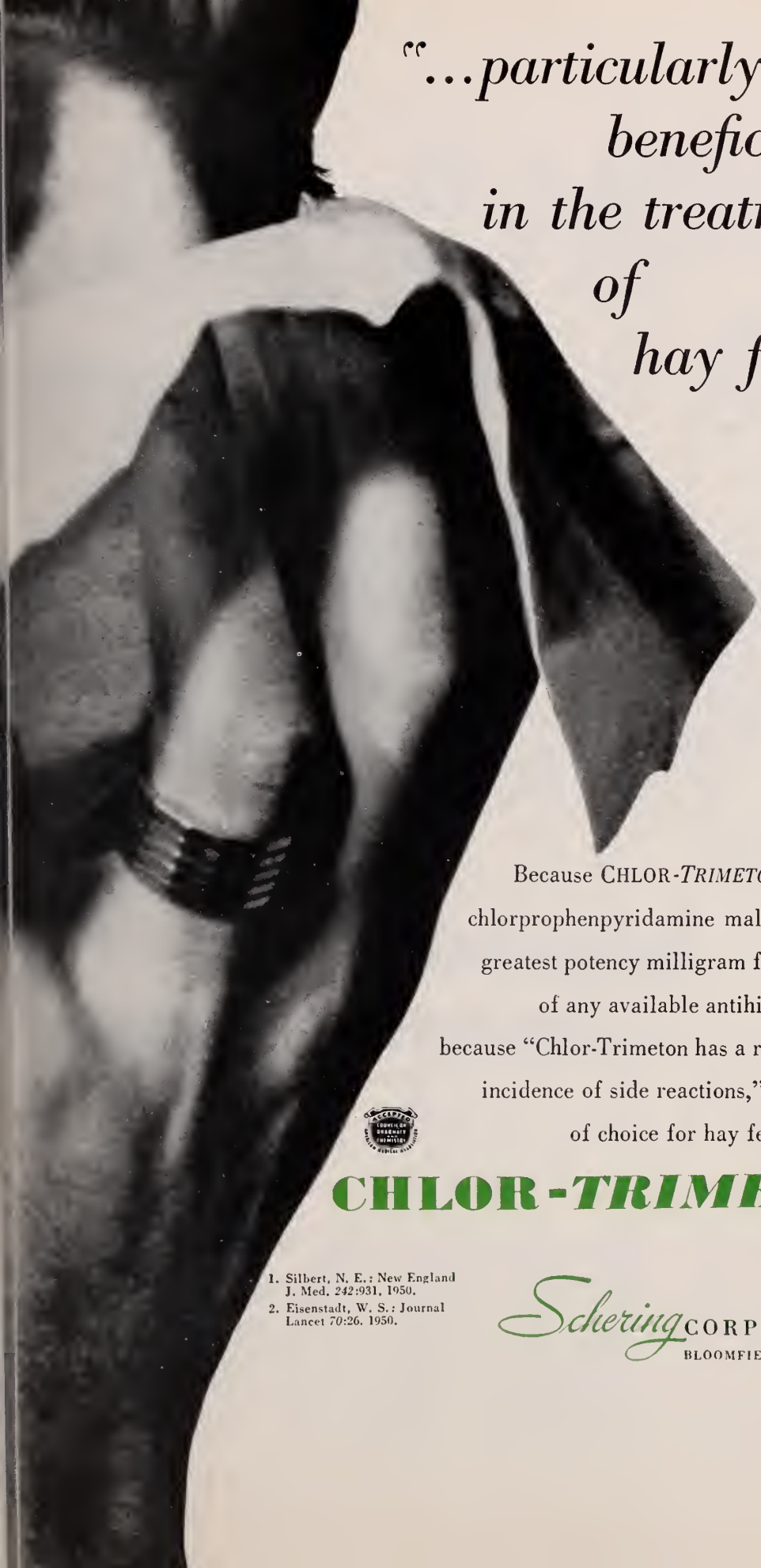
No physician could afford to devote much time and study to every new product. Your Council on Pharmacy and Chemistry renders this service for you, freely. Nowhere else in the world are there groups that perform the functions so ably served by the A. M. A.'s Council on Pharmacy and Chemistry, the Council on Foods and Nutrition and the Council on Physical Medicine and Rehabilitation.

Food and drug companies cooperate with the Councils on a free and voluntary basis. The Councils serve you by giving assurance that the product bearing it has undergone a careful examination. Ask your detail man, "Is this product Council Accepted?"

ACCEPTED
COUNCIL ON PHARMACY AND CHEMISTRY
AMERICAN MEDICAL ASSOCIATION

ACCEPTED
COUNCIL ON FOODS AND NUTRITION
AMERICAN MEDICAL ASSOCIATION

ACCEPTED
COUNCIL ON PHYSICAL MEDICINE and REHABILITATION
AMERICAN MEDICAL ASSOCIATION



"...particularly beneficial in the treatment of hay fever."[1]

Because CHLOR-*TRIMETON*® maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"[2] it is a drug of choice for hay fever patients.

CHLOR-*TRIMETON*
maleate

1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26. 1950.

Schering CORPORATION
BLOOMFIELD, NEW JERSEY

CHLOR-*TRIMETON*

SCHERING

The Right to *Choose* . . . .

CORNERSTONE OF AMERICAN LIBERTY

Hospital Expense Plans

Medical-Surgical Expense Plans

Paycheck Protection Plans

Life Insurance Plan

AS long as Americans keep the right to choose — their church, their political party, their doctor and their hospital — freedom must prevail.

We are proud that hundreds of thousands of Americans have freely chosen the protection afforded them by PENNSYLVANIA LIFE'S liberal, low-cost health insurance plan.

Pennsylvania Life
HEALTH & ACCIDENT **Insurance Company**

FOUNDED 1890

HOME OFFICE: PHILADELPHIA 5, PA.

19 District Offices in Florida

Miami	Executive Office	3028 Biscayne Blvd.	
	Downtown	1210 Pacific Building	
	Southwest	1260 S. W. 22nd Street	
	Little River	8340 N.E. Second Ave., Suite 245	
	Coral Gables	3028 Biscayne Blvd.	
	Miami Beach	206 Harvey Building	
St. Petersburg		509 White Building	
Lakeland		206 Marble Arcade	
West Palm Beach		305 Citizens Building	
Orlando		209 Slayton Building	
Fort Lauderdale		521½ South Andrew Avenue	
Jacksonville		303 Clark Building	
Tampa		228 Cass Street Arcade Building	
Sarasota		237 Main Street, Room 15	
Fort Pierce		Florida Bank Building, Room 34	
Daytona Beach		116½ Orange Avenue	
Tallahassee		429 Centennial Building	
Panama City		142 Harrison Avenue	
Pensacola		501 Theisen Building	

"PREMARIN"®

Highly effective • Well tolerated • Imparts a feeling of well-being

"PREMARIN"

The menopausal patient
welcomes the sense of well-being
imparted by "Premarin."

"PREMARIN"

Estrogenic Substances (water-soluble)

"PREMARIN"

also known as Conjugated Estrogens (equine)

"PREMARIN"

AYERST, McKENNA & HARRISON Limited • New York, N. Y. • Montreal, Canada

ILOTYCIN

(ERYTHROMYCIN, LILLY)

CRYSTALLINE

NOW
COUNCIL
ACCEPTED

Lilly

The Originator of Erythromycin

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXIX | Jacksonville, Florida, April, 1953 | No. 10

The Treatment of Badly Comminuted Fractures With the Rush Nail

AMSIE H. LISENBY, M.D.
PANAMA CITY

Badly comminuted fractures of the long bones have always been a serious problem and the cause of much concern to the general surgeon, as well as the orthopedic surgeon. Especially have compound comminuted fractures been the cause of much trouble and anxiety on the part of the surgeon, and of no little concern to the patient.

These fractures are of concern to the surgeon because of the difficulty of keeping them sufficiently reduced to allow osteogenesis without losing alignment. Then, too, if infection sets up due to contamination from compounding, it is well nigh impossible to maintain good alignment and treat the infection at the same time.

The badly comminuted fractures are of concern to the patient because of the long hospitalization necessary and the financial problem which arises. Of none the less concern is the thought of the possibility of the loss of a limb which has suffered a compounded and badly comminuted fracture.

The Rush Nail

The use of the Rush pin affords a most desirable and adequate method of treating these fractures. This pin, which is a piece of stainless steel and which comes in different sizes and lengths, was produced by Dr. Leslie Rush of Meridian, Miss., after long experimentation with intramedullary pins. It had just the proper temper and strength to adjust itself to hollow cavities such as the medullary canal in long bones. Because of the spring in the pin, it gives three point tension, and since it does not fill up the cavity, it allows the muscle tension to pull the ends of the bone together and hold them in this position. This action stimulates osteogenesis in itself, which is a potent factor in the healing of bone.

While my experience has been much less than that of others in the use of the pin, I believe that the cases I present demonstrate that this method of treatment is all that one could ask for (figs. 1-5). Also, I believe that the comminuted fractures shown in this series of 6 cases are about as badly comminuted as one could expect to encounter.

Fig. 1 Case 1.—Compound comminuted fracture of the tibia. A. Before open reduction. B. Two months after pinning.

In none of the cases was a plaster cast applied after fixation; instead, a metal splint was left in place until the tenderness and pain from the open reduction had disappeared after seven to 10 days. There was no evidence whatever of infection in any of the cases. Sulfanilamide was used freely in the wounds, and the patients received 100,000 units of penicillin every four hours for about seven days.

In all of these cases fixation was accomplished with the pin through open reduction. Of course, the closed method could not be employed as the fragments have to be wired around the pin, and the pin could not be guided through the medullary canal without one being able to see the pin as it crosses the fragmented area.

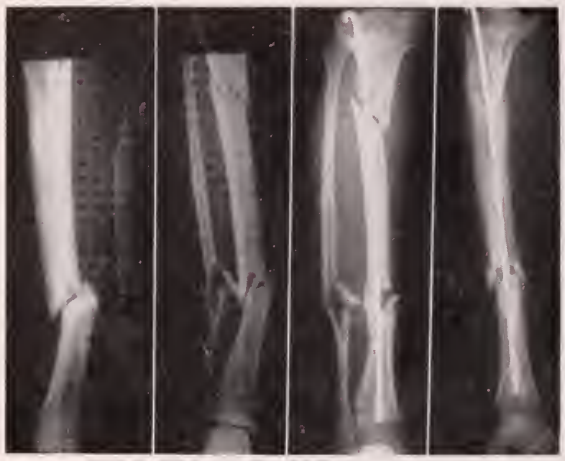


Fig. 2. Case 2.—A. Compound comminuted fracture of the lower third of the tibia and oblique fracture of the upper third of the tibia. B. Five months after pinning.

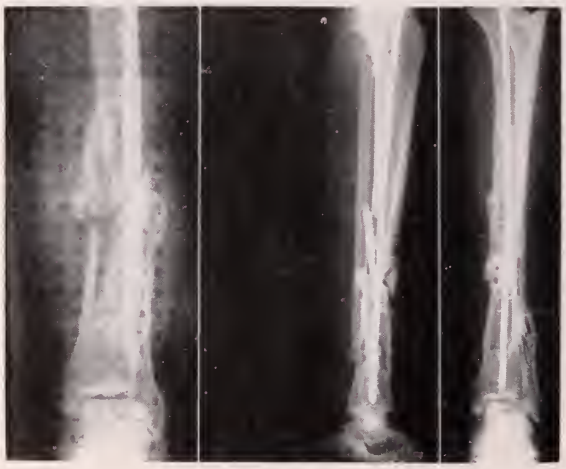


Fig. 3. Case 3.—A. Practically the whole lower third of the tibia was badly compounded and comminuted. B. Two months after pinning and wiring of fragments around the pin.

It has been my experience in the treatment of trochanteric and subtrochanteric fractures of the femur that better reduction with the intramedullary pin can be accomplished by the insertion of the pin from below. In the first place, it is hard to pass the pin from above down the medullary canal as it tends to pass out the opposite side of the canal or out through the fracture line. Secondly, angulation at the fracture site is better prevented when the pin is passed from below.

Dr. Rush informs me that he now has a pin with a long hook on it which fits down along the cortex of the bone and helps to prevent angulation.

Fig. 4. Case 4.—A. Badly compounded and comminuted fracture of the middle third of the tibia. B. Three months after pinning and wiring of the fragments around the pin. This pin was removed 15 months after pinning.

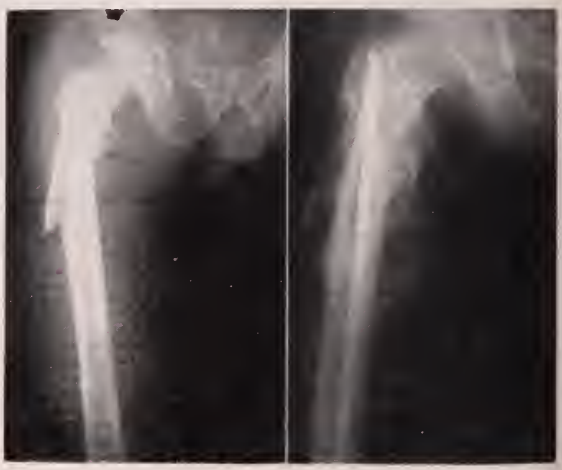


Fig. 5. Case 5.—A. Comminuted intertrochanteric fracture of the femur caused by the patient twisting the leg to "loosen" it up on arising. B. Three months after pinning. This shows the advisability of passing the pin from below on fractures around the trochanter. Much better results are obtained than by passing the pin from above.

In case 6 of the series there was fracture of the femur in a girl 5 years of age (fig. 6). In this case I tried to reduce the fracture and keep it reduced by means of a plaster cast. No damage is done if the pin is kept away from the epiphyseal

Fig. 6. Case 6.—A. Fracture of the middle third of the femur in a girl aged 5 after being reduced and a body cast applied for one month. B. Two months after open reduction and pinning. Note that the pin does not infringe on the epiphysis so that there has been no disturbance to the growth of the bone.

line. Not included in this series is a case of fracture of the femur in a child 4 years of age in which I employed the pin. Healing is prompt, and complete recovery occurs much earlier than when a cast is used.

Summary

A series of 6 cases is reported in which the Rush nail was employed in the treatment of badly comminuted fractures. The illustrations, showing roentgenograms taken before and after treatment in each case, adequately demonstrate the success with which this pin may be used.

Box 961.

Otitis Externa

William H. Turnley, M.D.
OCALA

The subject of otitis externa was chosen for presentation before the Ocala Journal Club because it seems to be a timely one for the summer season, as well as one of local interest to the general practitioner and specialist in this section of Florida.

As the term implies, this is an infection of the external auditory canal, but it is not specified whether the offending organism is fungus, bacteria, virus, or other agent. The idea, however, that the etiologic agent is a fungus is apparently deeply rooted among the laity.

Fungi are vegetable organisms of a low developmental order, widely distributed throughout the United States. They may exist as parasites (pathogens) on animals or vegetable life, or as saprophytes, living on dead vegetation. The common fungi, mold, yeast, and mildew, occur in the outdoor atmosphere. Spores in indoor air have been demonstrated 250,000 per cubic meter. They are even found in the high upper atmosphere. Not much mention is made of spores occurring in waters. These facts are brought out to show how common fungi are, but actually, the bacteriologic investigations of Syverton and Salvin and their associates and others have shown that the flora in approximately 75 per cent of the cases of otitis externa is exclusively bacterial, while in 20 per cent of the cases a mixture of bacteria and fungi is found, and in only 5 per cent of the cases is there a purely mycotic flora. Senturia found fungi in 3 per cent of normal ear canals. Diphtheroids and micrococci were found frequently in normal ears, and practically every ear showed staphylococci.

In a study reported by Quayle, the Pseudomonas aeruginosa (Bacillus pyocyaneus) organisms were found in 65 per cent of infected ear canals and were not found in normal ears. Fungi were rarely found. The "Review of Clinical Uses of Aureomycin" by Lederle, 1951, page 157, says, "Otitis Externa is now known to be a bacterial and not a fungus infection." Many types of bac-

Read before the Ocala Journal Club, Ocala, March 4, 1952.

teria are found, the predominating ones being of the genus Pseudomonas. No single organism or combination of bacteria occurs frequently enough to be considered a specific cause of otitis externa.

Manifestations

Otitis externa manifests itself in many different forms, depending on the person, type of infection, season of the year, and locality. In Connecticut and New York, there was much more of it after the troops returned from the South Sea Islands, following World War II. An interesting note from the tropics, Figi Islands, and Panama, where our soldiers were stationed during the war, is that otitis externa was common among the soldiers, but the natives did not have it. In Florida, it is five times more prevalent than in New York, and is definitely a summer disease. It develops more frequently in patients who go swimming in warm lakes, but patients also get it after bathing in cool springs, and some have it who do not go in either. Personally, I do not think they get the infection from the water, but dampness does encourage the growth of organisms already present. The condition seems to thrive better in the ear canal where there is darkness, moisture and warmth. A porous skin affords a better foothold for the growth, and probably food is furnished from the cerumen secreted in the ear canal. Some lesions are just minute cracks or scales, which are dry and itch or burn and bleed. This is often called eczema, which is also an unsatisfactory diagnosis.

Others have a thin, watery secretion, which may be clear, straw-colored, dark brown, yellow or green, depending on the predominant organism. This type usually occurs in persons who have a thin, dry skin, while others, with a thick, oily skin, are more prone to have a profuse exudate. Sometimes the whole canal is filled with an exudate like cream cheese, while other lesions are the fiery red weeping type, that may spread all over the outer ear, into the scalp, and down the neck. Some seem to be more deep-seated, producing cellulitis, with tremendous swelling and pain; the entire auricle may be involved and the canal completely occluded. This type may resemble acute mastoiditis, but if there is pain on pressing the tragus or pulling on the auricle, it is probably otitis externa. Others produce a discrete furuncle. Last summer, a girl patient, with a temperature of 104 F., had to be hospitalized and given opiates and sulfonamide drugs for several days. Pain is the most prominent symptom.

I should like to mention here 5 cases in which infection penetrated through the tympanic membrane from the outside. Penetration was demonstrated by inspection of the drum, by inflation of the eustachian tube, and by injecting a dye in the ear and noting the staining of the postnasopharyngeal region. There was no history of middle ear infection, and roentgen examination showed no demonstrable pathologic condition of middle ear or mastoid cells. So it seems this condition can vary from a mild annoying sensation to a severe acute infection, depending on the resistance of the individual patient and the virulence of the combination of organisms.

A great deal more can be said about otitis externa; some authors think that in all cases there should be cultures, but they would not be practicable under average conditions. I think all of us recognize most cases clinically.

Treatment

Treatment concerns us most. As for the chemicals and antibiotics used, their name is legion. This fact tells us we have no specific.

A standard remedy is a mixture of salicylic acid, acetone and alcohol drops. Other remedies are 70 per cent alcohol and boric acid, chloroform and ether. Some have wasted good gin for ear drops. Acetic acid has been used, as have gauze wicks soaked in vinegar; chromic acid, iodine, merurochrome, and Burow's solution have been tried. Nitrofuran or furacin and thymol have their advocates. Strong caustics, such as carbolic acid or silver nitrate, have given good results, but must be used with caution. During World War II, cresatin was the standard treatment in the Navy. X-ray and radium seed have been resorted to, also. Several years ago, all the sulfonamide drugs ran the gamut. Now the antibiotics, penicillin, streptomycin and terramycin, have been used extensively. I have seen no report of statistics on neomycin. Recently, there has been some discussion as to whether or not fungus infections are increasing as a result of antibiotic therapy. Personally, I have discontinued the use of most antibiotics locally.

May I use a few similes and aphorisms? First, I should liken otitis externa to Bermuda grass. Have you ever tried to get rid of that pest from your garden? You can pull it out by hand, cut it off with a hoe, burn it down and sow it with salt like the Romans did Carthage, but once the rain comes, and you relax your vigil, then go out and

look at your handiwork. Eternal vigilance is the price we pay for a cure.

My personal procedure is as follows: First cleanse the canal with a warm water douche. Then blot it dry with a bit of absorbent cotton held with bayonet forceps, being careful not to bruise the canal wall. The drying is necessary, for water seems to aggravate this condition. Some cleanse the canal with alcohol, then ether, which is a good procedure, for it not only dissolves out the oil, but helps to kill some germs, or at least to get them drunk. Of course, some canals are so completely occluded and painful, or the child wiggles so much, that this routine cannot be carried out.

Take a wisp of long staple absorbent cotton and twist into a slender plug, which will fit the canal. Then with a bayonet forceps, just touch the end in pure cresatin (metacresol acetate), not too much. Pack this wick up against the drum membrane and tightly into the canal. I suggest this tight packing because it stretches the ear canal lining, thereby opening the ostia of the numerous little sebaceous glands lining the external auditory canal, allowing the cresatin to penetrate more freely. The pressure also acts in an analgesic way. If there is actual pain from pressure against the drum membrane, the pack may be released slightly. This is an office procedure, for the patient cannot do it himself at home, and his relatives will not.

The antiseptic action of cresatin is due to metacresol, which is liberated slowly on prolonged contact with the tissue surfaces. Its oily character causes it to adhere tenaciously. Cresatin not only acts as an antiseptic and analgesic, but is hygroscopic, and its odor is not unpleasant.

This pack is left in for 24 hours. The next day it is removed, and a new wick is inserted without preliminary cleansing. After three or four treatments, the whole inside of the canal may look like it has been burnt too much. Quite the contrary, it is necessary to burn the surface epithelium off to get at the bottom of these little sebaceous glands. Again, it is like digging Bermuda grass out by the roots, rather than just skimming the top off with a hoe, which looks nice for a day or so. As an adjunct to this treatment, I sometimes tell girls, who have long hair shading the ear, to comb the hair back and point the ear towards the direct sunlight for 20 minutes a day. Also, other general measures are to be used. In some of the dry scaly types of otitis externa a cresatin ointment may be preferable.

After you are absolutely sure the condition is cured, then treat it for another week. In other words, as far as the germs are concerned, "never give a sucker an even break." Instruct the patient to return later if he notices any recurrence; then start the cresatin pack again. In most cases the disease can be cured in a week; in some less time is required, and in others it hangs on for months. As you all know, there is more than one way to kill a cat. It is not what you treat otitis externa with; it is how you treat it.

References

Alonso, M.: Otitis Externa in Puerto Rico; A Clinical and Bacteriological Study, Laryngoscope 61:1114-1122 (Nov.) 1951.

Anderson, J. R., and Steele, C. H.: Use of Nitrofuran Therapy in External Otitis, Laryngoscope 58:1279-1286 (Dec.) 1948.

Harris, H. W.; Kilhan, L., and Finland, M.: Local Streptomycin Therapy for Suppurative Otitis, Bacteriologic and Clinical Observations, Arch. Otolaryng. 49:69-77 (Jan.) 1949.

Johnston, W. H.: Otitis Externa, Ann. Otol., Rhin. & Laryng. 53:5-14 (March) 1944.

Kligman, A. M.: Are Fungus Infections Increasing as a Result of Antibiotic Therapy? J. A. M. A. 149:979-983 (July 12) 1952.

Quayle, A. F.: Otitis Externa in New Guinea, M. J. Australia 2:228-231 (Sept. 2) 1944, cited in Eye, Ear, Nose & Throat Year Book, 1945, p. 314.

Salvin, S. B., and Lewis, M. L.: External Otitis, With Additional Studies on Genus Pseudomonas, J. Bact. 51:495-506 (April) 1946.

Senturia, B. H., and Doubly, J. A.: Treatment of External Otitis; Use of Vehicles and Antibiotics in External Auditory Canal; in Vitro Studies, Laryngoscope 57:633-656 (Oct.) 1947.

Syverton, J. T.; Hess, W. R., and Krafchuk, J.: Otitis Externa; Clinical Observations and Microbiologic Flora, Arch. Otolaryng. 43:213-225 (March) 1946.

1206 East Ocklawaha Avenue.

Seventy-Ninth Annual Convention
Florida Medical Association
Hollywood, April 26-29, 1953

VOLUME XXXI
NUMBER 10

Pott's Fractures and Associated Injuries

LENOX D. BAKER, M.D.
DURHAM, N. C.

The privilege of appearing before the Florida Association of Industrial and Railway Surgeons is greatly appreciated. As medicine becomes more specialized, the choice of subjects of interest to an audience such as the group gathered here this afternoon becomes more limited.

"No part of surgery is thought to be so easy to understand as that which relates to fractures and dislocations. Even the most inexpert and least instructed practitioner deems himself perfectly qualified to fulfill this part of the chirurtic art: And the majority, even of these, are affronted by an offer of instruction on a subject with which they think themselves already so well acquainted.

"This is also the opinion of a considerable part of the people. They regard bone-setting (as it is called) as no matter of science; as a thing which the most ignorant farriar may, with the utmost ease, become soon and perfectly master of; nay, that he may receive it from his father and family as a kind of heritage." Thus wrote Percivall Pott in 1768 (fig. 1).[1]

What might have been true in the times of Pott is not necessarily true today. There exists, however, a lackadaisical attitude in the profession toward improving the methods of treating some of the common fractures that are classified as minor. Management of fractures and similar injuries about the ankle is fraught with much difficulty. Despite their frequency and the well established principles of their treatment, avoidable complications occur far too frequently, and it behooves all who attempt to treat fractures and sprains of the ankle to take stock occasionally in order to evaluate and better their methods of treatment and improve their end results.

From the Orthopaedic Division, Department of Surgery, Duke University School of Medicine, Durham, N. C.

Read before the Florida Association of Industrial and Railway Surgeons, Thirteenth Annual Meeting, Hollywood, April 27, 1952.

Classification of Fractures and Sprains About the Ankle

In his original thesis Pott described an injury consisting of a fracture of the fibula, a partial dislocation of the ankle, and a laceration of the ligaments that fasten the tibia to the astragalus and to the os calcis. Cotton[2] and others have

PERCIVALL POTT Esq^r

Engraved by Heath, from a Picture of Sir Joshua Reynolds.

Figure 1.

added new descriptions and classifications of various fractures about the ankle, and there are numerous names associated with the more common ankle fractures. Sprains of the ankle, particularly when there is a diastasis with a widening of the ankle mortise, are equally serious injuries. All such traumas can be classified as abduction or adduction injuries with or without dislocation. The dislocation may be to either side, forward or backward. The fracture may involve only one malleolus, or it may be bimalleolar or trimalleolar. (The posterior lip of the articular surface of the tibia is now referred to as the posterior malleolus of the tibia.)

Pathology

Little has been or can be added to Pott's original description of the pathology, and of the principles of the treatment of these injuries. A part of his description is therefore quoted:

"A case which, according to the general manner of treating it, gives infinite pain and trouble both to the patient and surgeon, and very frequently ends in the lameness and disappointment of the former, and the disgrace and concern of the latter — I mean the fracture of the fibula attended with a dislocation of the tibia. Whoever will take a view of the leg of a skeleton will see that although the fibula be a very small and slender bone, and very inconsiderable in strength, when compared with the tibia, yet the support of the lower joint of that limb (the ankle) depends so much on this slender bone that without it the body would not be upheld, nor locomotion performed, without hazard or dislocation with every movement. . . . This lower extremity of the fibula has, in its posterior part, a superficial sulcus for the lodgment and passage of the tendons of the peroneal muscles which are tied down by strong ligamentous capsulae, and have their action so determined from this point or angle that the sequence of external force must necessarily have considerable effect on the motions they are designed to execute and consequently distort the foot. . . ."

(When a lateral dislocation occurs, the tendons, especially the posterior tibial which pass through similar grooves in the tibia, not infrequently dislocate from their sheaths and slip into the ankle mortise. In such instances reduction of the fracture-dislocation is impossible until such tendons are surgically removed from within the joint.)

". . . . In this type injury, the fibula breaks in the weak part already mentioned, that is, within two or three inches of the lower extremity [fig. 2]. When this happens, the inferior fractured end of the fibula falls inward toward the tibia, that extremity of the bone which forms the outer ankle is turned somewhat outward and upward, and the tibia having lost its proper support and not being of itself capable of steadily preserving its true perpendicular bearing, is forced off from the astragalus inwards, by which means the weak bursal, or common ligament of the joint is violently stretched, if not torn, and the strong ones which fasten the tibia to the astragalus and os calcis (deltoid ligaments) are always lacerated: thus producing at the same time a perfect fracture and a partial dislocation, to which is sometimes added a wound in the integuments, made by the bone at the inner ankle. . . . When this accident is accompanied, as it sometimes is, with a wound of the integuments of the inner ankle, . . . it not infrequently ends in a fatal gangrene. . . . But in its most simple state, unaccompanied with any wound, it is extremely troublesome to put to rights,

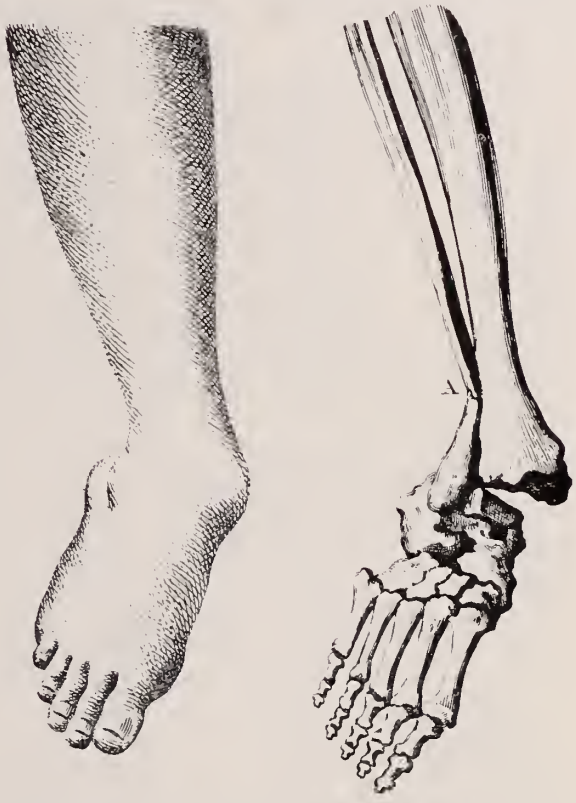


Fig. 2. — Pott's original illustration of the fracture now known by his name.

still more so to keep it in order and unless managed with address and skill, is very frequently productive both of lameness and deformity ever after."

Treatment

After such a description written about 200 years ago, it hardly behooves any of us to attempt to add details. But wait until you hear Pott's discourse on the treatment of his fracture.

In outlining treatment, he condemned any efforts at reducing the fracture with the limb extended at the knee and stated:

"This extension occasions the difficulty in reduction and the difficulty in keeping it reduced . . . but if the position of the limb be changed . . . with the knee moderately bent, the muscles forming the calf of the leg and those which pass behind the fibula and under the os calcis all are put into a state of relaxation and non-resistance, all this difficulty and trouble do in general vanish immediately; the foot may easily be placed right, the joint reduced, and by maintaining the same disposition of the limb, every thing will in general succeed very happily, as I have many times experienced."

As has already been said, little has been or can be added to Pott's description of this fracture and of the principles of its treatment. The failure, however, to perform properly certain details in the reduction and fixation of a Pott's fracture may lead to "lameness and disappointment."

The time allotted for presenting this paper does not allow a detailed description of the signs of Pott's fracture, nor a description of all the accepted methods of reduction. The following principles, as previously described,[3] may be stated as holding true regardless of the method used:

ROENTGENOGRAPHIC EXAMINATION. — Roentgenograms should be made of all injured ankles. In addition to the usual anteroposterior and lateral views, oblique views should be included in order to visualize diastasis.

ANESTHESIA. — General or spinal anesthesia is preferable to local anesthesia.

REDUCTION AND APPLICATION OF CAST. — Traction in the line of deformity to realign the fragments is the first and most important force to be applied. This traction should be applied with the patient's knee flexed to a 90 degree angle and with counter traction applied over the posterior aspect of the thigh just above the knee by an assistant, by a fixed strap, or, preferably, by the end of the table. Counter traction thus applied allows for relaxation of the musculature of the leg.

Figure 3a shows the position of the surgeon for reduction of an abduction fracture. The hand corresponding to the injured ankle grasps the leg with the inner malleolus fitted into the palm and the thumb placed medially along the shaft of the tibia. The opposite hand grasps the heel with the lateral malleolus well cupped in the hollow of the hand. Traction is applied on the heel, the astragalus and the foot are forced inward with the outer hand, and the tibia is forced outward by the inner hand, but the foot is not supinated. The astragalus is aligned with the tibia and the os calcis, with the foot in the mid position.

If anatomic restoration is to be secured, manipulation should be directed toward bringing the astragalus into alignment with the tibia, realigning the fracture fragments, restoring the joint mortise and, if present, reducing the fracture of the posterior malleolus of the tibia. When the distal fragments and the astragalus are reduced, traction must be maintained with a forward force to prevent recurrence of backward dislocation. The foot should be placed at an angle of approximately 90 degrees to the leg, or in slight plantar flexion. Care must be taken not to overdorsiflex the ankle, as the astragalus, which is wider in the front than in the back, will force the malleoli apart, thus spreading the ankle mortise.[4]

Following reduction, the forefoot may be supported by resting the head of the fifth metatarsal lightly on the operator's knee, or an assistant may support the forefoot. A long, thoroughly soaked wet plaster splint is then placed in sugar tong or stirrup fashion about the leg, the ankle, and the posterior part of the foot. This plaster slab should be well molded and held with plaster bandages (fig. 3b).

We use the unpadded cast. If the unpadded cast is not used, the plaster stirrup should be put on unpadded; a light layer of glazed cotton may then be wrapped on in a circular fashion before application of the circular plaster bandage. It has been our experience that with proper precautions and care, less circulatory embarrassment, fewer pressure sores, and better fixation result with the unpadded cast than with the padded cast.

After the sugar tong splint has been well molded, an additional plantar splint may be applied and molded to support the longitudinal and metatarsal arches (fig. 3c). When the cast is completed, the dorsal surface should extend to the web

Fig. 3.—(A) With the patient anesthetized and the knee of the injured extremity flexed over the edge of the table, the operator applies traction. (B) When the cast is completed about the ankle and leg, it is extended out over the forefoot. (C) An additional plantar splint may be applied and molded to support the longitudinal and metatarsal arches. (D) A section of an automobile tire with good tread makes a satisfactory weight-bearing appliance.

spaces of the toes. The plantar surface should extend to the tips of the toes.

If the fracture has been properly reduced, and the foot has been put into an anatomic position, weight-bearing forces will not disturb the reduction. The active use of the limb stimulates union and prevents circulatory stasis, lessens atrophy, and avoids stiffness. A section of an automobile tire with good tread makes a satisfactory weight-bearing appliance. The tread is applied in weight-bearing alignment, with a firm block of sponge rubber between it and the cast (fig. 3d). The tread and the sponge rubber are held in place by an additional circular plaster of paris bandage. Regardless of the type of cast applied, either padded or unpadded, any sign of circulatory embarrassment, no matter how mild, is sufficient reason to split the cast.

TREATMENT FOLLOWING REDUCTION. — In all instances, postreduction roentgenograms should be made to make sure that the ankle mortise has been restored, that the fibula is in normal alignment, and that the dislocation is reduced. In the anteroposterior view, the superior articular surface of the astragalus must be in anatomic relationship with the articular surface of the tibia. If this relationship has been restored but still the mortise appears widened, a control roentgenogram of the uninjured ankle should be made for comparison. In the oblique view, the lower tibiofibular articulation must be in normal relationship. In the lateral views, the superior articular surface of the astragalus must be in contact with the anterior portion of the articular surface of the tibia.

A posterior fragment from the lip of the tibia, if it includes an appreciable amount of the articular surface, should be brought into normal relationship. Otherwise the position of this fragment is not particularly important. It will often be impossible to correct its slight upward displacement, but as long as it is displaced away from the joint rather than into the joint, exact reduction is unimportant.

Immobilization is usually required for eight to ten weeks. It should be continued until bony union has occurred. If the fracture has been treated by a weight-bearing cast, on removal of the support, the ankle and foot should go through approximately a normal range of motion. Following removal of the cast a jelly bandage is usually of benefit in preventing recurrent swelling. If necessary such a boot should be continued for several weeks.

The patient or those responsible for the patient should be supplied with instructions for observing signs of circulatory changes. A satisfactory fracture instruction sheet is as follows:

ACCIDENT DEPARTMENT
INSTRUCTIONS IN FRACTURES CASES

It is important that the circulation of blood in the fractured limb be watched closely. In order to watch the circulation, the fingers or toes of the fractured limb have been left exposed.

Keep the injured part elevated. If the exposed parts become BLUISH, SWOLLEN, COLD OR NUMB, return AT ONCE to the hospital. Otherwise, PERMANENT INJURY MAY RESULT.

Return to the hospital tomorrow as instructed by the doctor who set your fracture, so that he can inspect the cast, circulation, etc. Following this, come to the Fracture Clinic as instructed on Friday at 8:30 a.m. until discharged.

I have received a copy of the above instructions which have been explained to me and are clear as to details.*

Signed .....

(*Explain and give one copy of instructions to the patient and attach a signed copy to the record.)

The Hazards of Open Reduction

Unfortunately in the past few years several articles have appeared in the literature recommending open reduction and some type of internal fixation in fractures about the ankle. Figure 4 is a good example of the foolhardiness of such measures. In this instance, the surgeon has performed an open reduction and has inserted a screw through a posterior fragment of the tibia. Failure to reduce such a fracture by conservative measures is usually followed by the same failure when surgery is resorted to. In this case there is nonunion of the medial malleolus, and the joint mortise has not been restored. In spite of the open reduction for the posterior fragment, its position has not been changed. Compare figure 4 with figure 5, in which relatively the same fracture has occurred with severe comminution of the lateral malleolus. By sufficient traction and manipulation all fracture fragments were aligned and the luxation was reduce; the posterior fragment is in a satisfactory position, and the joint mortise is restored.

Treatment of Uncomplicated Malleolar Fractures

Malleolar fractures without luxation of the joint and without displacement of the fragments should be treated symptomatically. Frequently procaine injection followed by heavy adhesive strapping or by the application of a Delbet cast,[5] preferably the latter, gives excellent end results and allows the patient to dress in a customary fashion and to walk with a normal gait.

Fig. 4.—(A) Lateral view of a trimalleolar fracture with a small posterior fragment and very little interference with the weight-bearing surface of the tibia. (B) Anteroposterior view showing slight lateral displacement of the astragalus and fracture of the medial and lateral malleoli. (C) An open reduction has been done, with the screw inserted through the posterior fragment of the tibia. (D) There is nonunion of the malleolus, and the joint mortise has not been restored. The astragalus shows lateral luxation, and the position of the posterior fragment has not been changed.

A Delbet cast (fig. 6) is prepared of two heavy plaster splints placed laterally and medially on the leg and folding back on themselves for increased strength at the foot and malleolar areas. Felt pads are used over the malleoli and sides of the foot, and a circular felt pad is used about the top of the cast. The splints are wrapped on snugly by a circular bandage. After setting, the circular bandage is trimmed about the foot as in figure 5. This cast gives good lateral and medial stability at the subastragalar joint without interfering with flexion and extension of the ankle.

Sprained Ankles with Diastasis

Sprains of the ankle are one of the most frequent injuries encountered. Treatment without thought to the ligamentous damage produced by this so-called minor injury may result in partial permanent disability.

The most unstable position of the ankle joint is in plantar flexion.

It is probably unfortunate that the peroneus tertius is not a stronger muscle. If it were, it might aid in the strength and stability of the lateral aspect of the joint and probably save the weak anterior talofibular ligament many injuries.[6]

Clinically, after such an injury, it is difficult to determine the extent of damage to the ligaments. By anteroposterior roentgenograms, however, with the foot held in forced inversion, ligamentous tears can be demonstrated by a subluxed talus. In certain persons, there may be from 5 degrees to as much as 10 degrees normal tilt to the talus with the foot in forced equinovarus. Their normal position can be established by roentgeno-

Fig. 5.—Conservative therapy consisting of manipulation with the patient anesthetized and the knee flexed at a 90 degree angle has restored satisfactory alignment to all fragments and has reduced the lateral luxation of the astragalus.

grams of the opposite ankle. If fractures and ruptures of the ligaments are absent and the tenderness can be well localized, procaine infiltration and strapping of the ankle constitute the treatment of choice.

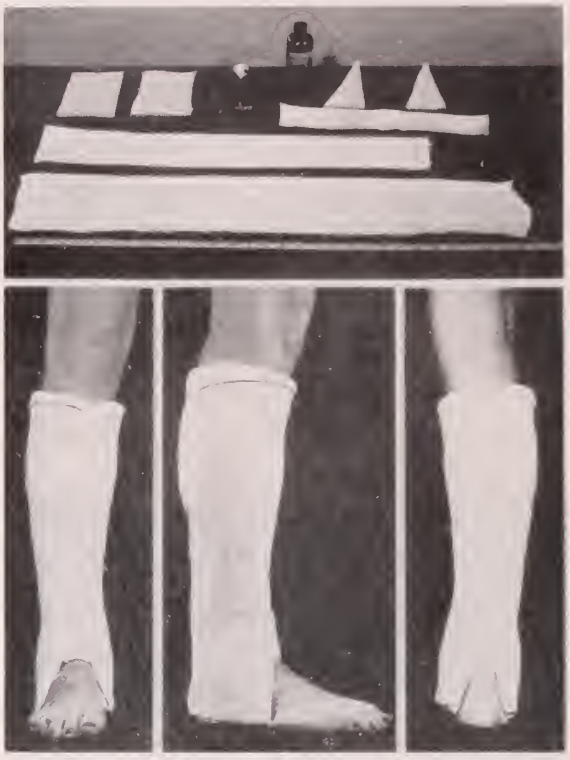


Fig. 6.—The material for a Delbet cast consists of: (1) Two squares of felt for the malleoli and sides of the foot; two triangular felt pads for the anterior and posterior aspects of the ankle; a felt strip for the top of the cast and a good glue for fixing the felt. (2) Two plaster splints five thicknesses sufficiently long to allow a short foldback at the top of the cast and a 6 to 8 inch foldback at the ankle. The edges of the plaster should be folded over ½ inch or so for strengthening. When the cast is properly applied, the lateral tongues at the ankle and foot reach the weight-bearing surface of the foot. The top of the cast is trimmed to allow for full knee flexion.

One of the most logical explanations for relief of symptoms by procaine infiltration is that histologically the articular ligaments are interspersed with numerous sensitive nerve endings. In sprains, the ligamentous trauma is accompanied by a violent excitation of the rich, autonomic nerve supply. The inability of the joint to function following the injury is a consequence of this violent stimulation. Local analgesia suppresses the irritation. When the pain impulses are eliminated, vasomotor changes are less likely to occur. During the first phase of muscle spasm after trauma, there is a transient vasoconstriction followed by vasodilatation. Stasis results producing anoxia and further muscle spasm. In breaking this cycle, pain is relieved, circulation is improved by active motion, and the swelling and stiffness are materially reduced.

It must be remembered that if pain persists after proper therapy of local analgesia and strapping of the ankle, there is some other factor complicating the simple sprain.

In diagnosing acute subluxations of the talus as a result of ligamentous tears, the history is most important, as it ascertains the mechanism of injury. The patient usually states that there was a "snapping," "slipping out of place," or "giving way" of the ankle.

Because of muscle spasm present immediately following local trauma even with local analgesia, roentgenograms of the inverted ankle may not reveal the full amount of subluxation. Under the general anesthesia the tilt of the talus may be increased 20 degrees or more.

Proper roentgenograms are important as disability may develop if correct diagnosis is not made.

In the treatment of acute subluxations of the talus a short leg plaster cast should be applied as in treating a Pott's fracture. The cast should be changed as often as necessary to maintain at all times a snug fit to the lower extremity. A walking tread may be applied at any time, as long as the cast maintains a firm lateral grip about the foot and leg. The ankle should be immobilized for a period of at least six weeks.

Conclusions

Pott's fracture is a common fracture, which "is extremely troublesome to put to right, still more so to keep . . . in order."

With the knee flexed and with strong traction applied, proper manipulation can produce anatomic reduction.

Reduction, once secured, should be maintained with the ankle at an angle of 90 degrees or in slight plantar flexion and with the foot in a mid position between supination and pronation (the weight-bearing position).

With adequate reduction and proper fixation, early weight-bearing is not contraindicated.

Stress should be placed on proper diagnosis and differentiation between simple sprain and extensive ligamentous damage to the ankle joint.

A Pott's fracture or a severe sprain, when not properly reduced and so held, "gives infinite pain and trouble both to the patient and surgeon, and very frequently ends in the lameness and disappointment of the former and the disgrace and concern of the latter."

References

1. Earle, J.: Chirurgical Works of Percivall Pott, F.R.S. Surgeon, St. Bartholomew's Hospital, a new edition with his last corrections, London, Wood & Sims, 1808, v. 1.
2. Cotton, F. J.: Tr. Orthopedic Section, American Medical Association, 1914; Dislocations and Joint Fractures, ed. 2, Philadelphia, W. B. Saunders Company, 1924.
3. Baker, L. D.: General Remarks on Pott's Fracture, North Carolina M. J. 9: 550-555 (Nov.) 1948.
4. Ashhurst, A. P. C., and Crossan, E. T.: Prognosis and Treatment of Fractures of the Tibia and Fibula, Tr. Am. Surg. Assoc. 41:594, 1923
5. Delbet, P.: Methode de Traitement des Fractures, Paris, F. Alcan, 1916.
6. Moorehead, S. F.: Sprains and Subluxations of the Ankle Joint, Orthopedic Correspondence Letter, National Foundation for Infantile Paralysis, Inc., Training Program, Duke University, Durham, N. C., February 1952.

Orthopaedic Division, School of Medicine, Duke University.

A Phase of Postpartum Bleeding With Case Reports

Merritt R. Clements, M.D.
TALLAHASSEE

Most of the physicians here this afternoon can remember cases of postpartum bleeding which presented an abnormal picture in that the blood did not seem to clot and in spite of adequate blood replacement the patient expired from hemorrhage. Many of you can recall patients who did not expire, but bled profusely from no known cause and recovered after adequate blood replacement.

I should like to present for discussion 3 cases that would come under the second category. Hemorrhage is the second most common cause of maternal deaths in this section of the country. It is exceeded only by toxemia. During the period 1949-1951 there were 44 deaths in Florida from hemorrhage, 2 in Leon County. During the same period there were 96 deaths from toxemia, 3 of these in Leon County. There are many causes of postpartum hemorrhage, such as uterine atony, brought on by prolonged or precipitate labor; overdistention of the uterus from polyhydramnios, due to monstrosity or multiple pregnancy; prolonged and deep anesthesia; mismanagement of the third stage; trauma during delivery from forceps or manual force; uterine, cervical, vaginal or perineal lacerations; uterine tumors, and many other less common causes. Moloney, Egan and Gorman[1] in 1949 reported a case of acquired afibrinogenemia in pregnancy. Since that time there have been many reports of coagulation defects in the blood causing in some cases extreme hemorrhage in the postpartum period of pregnancy.

In the 3 cases presented here there was clinical evidence of a coagulation defect in the blood. Intrauterine death from Rh isosensitization occurred in the first case. In the second case there was a premature separation of a normally implanted placenta in a patient without evidence of toxemia. Toxemia of pregnancy was present in the third case.

Report of Cases

Case 1.—Mrs. D., a white gravida III, Para I, aged 30, was in good general health when first seen on Jan. 12, 1952. The last menstrual period occurred on Oct. 3, 1951. The expected date of confinement was July 10, 1952. The blood was Rh negative, type O. The Kahn test gave negative results. The husband's blood was Rh positive. There was a history of a normal 18 hour period of labor in 1940, with delivery of a 7½ pound female infant, now 11 years old and in good health. A second pregnancy terminated with delivery of a stillborn, 9½ pound male infant on Sept. 25, 1944. Labor was induced because of the dead baby. Severe hemorrhage necessitated giving three blood transfusions postpartum. The transfusions were cross-matched, but no Rh determinations were made as the procedure was not available at the time in the hospital where the patient was delivered. The agglutination titer on April 18 was 1:64; the blocking antibody titer was 1:256.

The patient had a normal antepartum course, except for a cold, until April 17 when she was six months pregnant. At that time no heart tones were heard, and no fetal movement was noted. The impression of intrauterine death was made. Two months later, on June 17, ecchymotic areas were noted on both legs and forearms. The platelet count, bleeding time and coagulation time at that time were normal.

She was admitted to the Tallahassee Memorial Hospital nine days later, on June 26, three weeks before term, in active labor. Three hours after admission she was delivered of a macerated male fetus and placenta intact. Although the uterus remained firm and well contracted, blood continued to trickle and would not coagulate. She had been given vitamin K on admission. Blood replacement was started, but in spite of transfusions, the bleeding occurred faster than the blood could be replaced, and shock increased. Three hours after delivery she was anesthetized with nitrous oxide and ether. The uterus was explored thoroughly and packed firmly with two uterine packs. The patient received 2,500 cc. of blood during this time. There was only a moderate amount of bleeding around the pack, and the fundus remained firm thereafter.

The ecchymotic areas on the arms and the legs gradually cleared up within the next two or three weeks. The patient made an uneventful recovery

Read at the Northwest Medical District Meeting, Panama City, Oct. 27, 1952.

Case 2.—Mrs. G., aged 28, was a white gravida III, Para II. Her first baby, delivered in 1944 after a normal three hour period of labor, was a 6 pound male infant, now 7 years old and well. The second pregnancy was terminated in 1946 after a 10 hour period of labor with the birth of a 7½ pound male infant. This child died of poliomyelitis at the age of 3 years. The last menstrual period of the present pregnancy occurred on Oct. 12, 1951. The expected date of confinement was July 19, 1952. The general health of the patient had always been excellent. The antepartum course was normal, and she gained 16 pounds. The blood pressure and results of urinalysis were normal throughout.

On June 29, 1952, three weeks before the expected date of confinement, while cooking dinner the patient experienced a sudden pain in left lower quadrant of the abdomen followed by profuse hemorrhage. She was brought into the emergency room of the hospital a few minutes later in shock, her clothing saturated with blood. Abdominal examination revealed a tense rigid uterus. No fetal heart tones were heard. She was taken directly to the operating room, put in the Trendelenburg position, and given intravenous glucose while the blood was being cross-matched. After administration of blood was started in both arms, a careful sterile vaginal examination was performed. The cervix was dilated 2.0 cm., but was soft and workable. The membranes were ruptured, and pitocin, minims ½, was given every 15 minutes. After the membranes were ruptured, the fetal heart tones were heard faintly. It was noted that approximately 150 cc. of blood which fell on the floor during examination did not coagulate at all. A basin was kept against the perineum to measure the exact amount of blood lost, and it was observed that the blood did not clot.

The patient was admitted at 1:40 p.m., and a living child was delivered at 5 p.m. The placenta came out directly following the baby, along with 300 cc. more of blood. The uterus contracted well, but blood that would not clot continued to trickle. The patient was redraped and put to sleep with ether. The uterus was thoroughly explored and the vagina and uterus thoroughly packed. During this procedure she received 2,000 cc. of blood. There was only a small amount of bleeding through the pack.

The patient made an uneventful recovery. The baby died on the third postnatal day.

Case 3.—Mrs. D., a white gravida II, Para I, aged 34, experienced her first pregnancy in 1946, with spontaneous delivery, after a 38 hour period of labor, of a 6 pound 14 ounce female infant, now 5 years old and in good general health. The patient's health had in general been excellent. An appendectomy had been performed in 1945. The last menstrual period occurred on May 8, 1951. The expected date of confinement was Feb. 12, 1952. The antepartum course was without incident and the blood pressure, weight and results of urinalysis normal until when seven and a half months pregnant she had a sudden active hemorrhage from the vagina and passed several large blood clots. She was seen at the hospital and admitted for a three day period of observation. During this time the bleeding subsided, and sterile vaginal examination showed no cause for the hemorrhage. The patient was discharged.

She was seen in the office two weeks later. At that time the blood pressure was elevated to 146 systolic and 84 diastolic. The weight remained the same. Urinalysis gave normal results, and the blood pressure remained around 132 to 144 systolic and 80 diastolic until she was admitted to the hospital on Feb. 17, 1952, five days after the expected date of confinement, because of slight bleeding. A sterile vaginal examination was made, and there was no evidence of placenta praevia. The membranes were ruptured, and nine hours later there was full dilatation. The blood pressure was 158 systolic and 90 diastolic. There was a normal spontaneous delivery with pudendal block. The placenta delivered intact, and there was a ruptured vein on the periphery of the placenta which I thought accounted for the early slight bleeding. The patient was given ergotrate and pitocin. The uterus contracted normally. The estimated loss of blood during delivery was only 75 cc.

Two hours postpartum bleeding began, and the patient was taken back to the delivery room. The estimated loss of blood was 500 cc. at that time. The blood was clotting. The uterus was packed. An hour later there was still bleeding around the pack. The patient was anesthetized, the pack removed, the uterus thoroughly explored, and the uterus and vagina thoroughly packed. During this period of time she received 2,400 cc. of blood.

Five hours later bleeding continued through the pack although the fundus of the uterus was hard and the patient was having labor-like contractions of the uterus that were extremely painful. The blood ran through the pack like water, and there was no clot formation at this time. The blood pressure was still up to 140 systolic and 100 diastolic. A quick supravaginal hysterectomy was performed. The patient received a total of 3,400 cc. of blood between 7 p.m. and 3:40 a.m. The blood pressure immediately following the operation rose to 174 systolic and 110 diastolic, and the patient was treated with magnesium sulfate as is the usual patient in the pre-eclamptic state. The pathologic report described a postpartum uterus with no abnormalities noted.

The patient made an uneventful recovery. When she left the hospital on the ninth day, the blood pressure was 130 systolic and 80 diastolic. Six weeks postpartum the blood pressure was 136 systolic and 90 diastolic. Urinalysis gave negative results at this time.

Comment

From the available literature it seems that there is present within the uterus, either in the fetus or the placenta or both, some agent that is capable of destroying the fibrinogen in the blood stream and thus setting the stage for the tremendous loss of blood that occurs in cases of the types described. In a study of 15 cases of intrauterine death from Rh isosensitization, Weiner, Reid, Roby and Diamond[2] noted that in only 3 were there severe coagulation defects. In a similar study of premature separation of the placenta, Weiner, Reid and Roby[3] presented 3 cases which led them to conclude that (1) there was a defect in the coagulation mechanism, and (2) blood changes were characterized by decrease in fibrinogen concentration and prothrombin activity and the presence of a circulating fibrinolysin.

To anticipate a hemorrhagic diathesis is the first step in the treatment of these conditions. Any patient who is bleeding or is toxic or has been carrying a nonviable fetus should have the coagulation mechanism of her blood studied. Bleeding time, clotting time, clot retraction time, platelet count, and prothrombin time should be determined. It is apparent that any hospital assuming responsibility for the care of obstetric patients should have available a blood bank. Any patient who has a disturbance in the clotting mechanism which is due to a lack of fibrinogen in the blood stream, according to the reports of the authors cited,[1-3] should have fibrinogen given intravenously along with the blood replacement. The fibrinogen is at present available only on experimental bases, but Diamond stated in a personal

communication that it should be available through commercial sources in the near future. Reid suggested that 6,000 mg. of fibrinogen appears to be the correct total amount to administer.

Since the only source of fibrinogen at present is blood, it should be emphasized that the blood must be given rapidly and in large quantities. Otherwise, it will be of no avail, since the blood given slowly in the veins will be so diluted that its fibrinogen content would not be felt and would be of little aid to the patient.

Summary

A phase of postpartum bleeding is discussed in which profuse hemorrhage of unknown etiology is followed by recovery after adequate replacement of blood. Three illustrative cases presenting evidence of a coagulation defect in the blood are reported, one each of intrauterine death from Rh isosensitization, premature separation of a normally implanted placenta with no evidence of toxemia, and toxemia of pregnancy.

The importance of anticipating a hemorrhagic diathesis and of administering blood rapidly and in large quantities is discussed, as is also the value of giving fibrinogen intravenously along with blood replacement as soon as this substance becomes available commercially.

References

1. Moloney, W. C.; Egan, W. J., and Gorman, A. J.: Acquired Afibrinogenemia in Pregnancy, New England J. Med. 14: 596-598 (April 17) 1949.
2. Weiner, A. E.; Reid, D. E.; Roby, C. C., and Diamond, L. K.: Coagulation Defects with Intrauterine Death from Rh Isosensitization, Am. J. Obst. & Gynec. 60:1015-1022 (Nov.) 1950.
3. Weiner, A. E.; Reid, D. E., and Roby, C. C.: Coagulation Defects Associated with Premature Separation of Normally Implanted Placenta, Am. J. Obst. & Gynec. 60:379-386 (Aug.) 1950.

1307 Miccosukee Road.

The Importance of Early Treatment of Childhood Allergy in Modifying and Preventing Adult Allergic Disorders

W. Ambrose McGee, M.D.
West Palm Beach

In the early part of the twentieth century there was a morbid dread of such prevalent diseases as typhoid, diphtheria, tetanus, whooping cough and many other contagious or infectious diseases. This fear has been wiped out by preventive measures and immunization. For many other equally severe diseases, such as meningitis, pneumonia and measles, no immunization is available; however, these diseases have their sting removed and their devastating effects controlled by the use of antibiotics and immune gamma globulin. Some infections, notably tuberculosis and poliomyelitis, as yet have not responded consistently to immunization or modification, but early recognition and treatment are especially valuable.

Read before the Florida Allergy Society, Fourth Annual Meeting, Hollywood, April 27, 1952.

As in tuberculosis and poliomyelitis, it is of great importance to recognize and to treat allergic disorders in children as soon as possible in order to modify and prevent adult allergic disorders.

The care of allergic disorders falls largely into the hands of the internist rather than the pediatrician. Up until five or 10 years ago there was a great deal of apathy on the part of pediatricians in regard to allergy. It is most fortunate that more interest is being shown, as the pathology associated with allergy is generally considered reversible in childhood while in adult life it is usually irreversible.

In the construction of a house one does not build before plans are studied and the foundation laid. In medical schools, however, the procedure is reversed. Medical students are taught more about adults than children and later have to spe-

cialize in the treatment of children. The logical sequence, it seems to me, would be to teach more about early life problems and specialize in adult disorders. It would be better for physicians who handle young children to recognize and treat allergic problems rather than those who deal largely with adults. By adequate training of pediatricians in allergic diagnosis and treatment, the early recognition and proper treatment should either stop or reduce to a minimum the allergic problem.

Pediatrician's Role in Early Recognition

To my mind the pediatrician has the key to much of the solution of allergic troubles. It is he who sees suspicious recurrent symptoms at their earliest. If he recognizes the trouble as allergy or potential allergy, he can often overcome it or at least reduce its frequency and severity. The internist-allergist rarely sees early allergy, for when a case is referred to him, it is usually full-bloomed and easily recognized.

A simple routine for watching potential allergy was developed after a review was made of symptoms which recurred in 150 well babies. They were seen regularly each month until they were one year of age. No infants were included in the study who came irregularly or who were referred for allergic studies.

In order to take full advantage of the information obtained, mothers were allowed to talk, and numerous questions were asked at each visit. It is unfortunate that the great demands on pediatricians' time and the enormous increase in overhead do not permit them to spend optimum time with each patient. With too brief a monthly visit, sufficient time is usually not available to elicit adequately untoward symptoms which enable one to recognize allergy in its earliest forms.

If a regular routine of waiting first five then three days is allowed after the ingestion of each new food, maximum information can be obtained as to whether or not that food disagrees. Should it produce untoward symptoms, as excessive spitting up, vomiting, colic, abdominal pain, diarrhea, constipation, mucus in stools, papular facial rash, perianal erythema, nasal discharge, excessive sneezing or sleeplessness, they would suggest a sensitivity to that particular food. Simple avoidance of that food for about one to three months is then in order. After a period of waiting, most offending foods can be tolerated, especially if not eaten daily. Foods which are persistently disliked or refused should be left alone for a month or two and then retried.

When there is a definite allergy to milk, it is generally useless to change from cows' milk of one kind to that of another. Should the infant be on a formula requiring boiled cows' milk and still have trouble, it is wise to switch to the milk of a different animal, as goat milk. The reason is that the milk of all animals differs in lactalbumin; so when one disagrees, another might agree. If improvement does not follow, then do not continue animals' milk, but change either to a soybean milk or a hydrolysate formula. While the lactalbumin differs in animals' milk and while boiling denatures the lactalbumin sufficiently to overcome allergy to milk in some cases, the casein is the same in all animals' milk.

There is a tendency of mothers to put pressure on their infants' physicians to feed solid food at too early an age. The pediatricians who usually agree with this statement are those who have been practicing for one or two decades, those who have had allergic infants of their own, or those who are immensely interested in allergy with their pediatrics. Wood mellows with age, and physicians, I believe, do likewise, becoming more cautious as time passes on. The introduction of cereals before the infant is three months old is possibly a little early in most cases. Likewise, I believe fruits and vegetables should be kept away till the average infant is about four or five months of age. Egg white should be disallowed the first year and egg yolk fed at about six months of age. Meats can be fed earlier than formerly, because they are obtainable in a strained form. A good age would be in the neighborhood of two to four months.

Avoidance of mixed foods and vitamins, as vegetable soups, liver soups, fish oils, and mixed fruits, enables one to recognize food disorders earlier. When vitamins are used, multiple, all synthetic water-soluble vitamins are to be preferred as they are far less allergenic than natural single or mixed vitamins.

Earliest Symptoms

The earliest allergic symptom is probably colic. The use of that term is considered unscientific. In residence training in pediatrics, the majority of pediatricians see or hear little about colic. "Teething" and colic are considered as terms unworthy of a scientific mind. Be that as it may, those physicians who have allergic infants of their own or those parents and grandparents who have their share of common sense, think colic and teething are descriptive of untoward symp-

toms occurring far too often in infancy. Proper recognition of colic and attempts to discover its cause are well worth while.

Many adults who have a definite allergy will inform the allergist on close questioning that he or she was a colicky baby. Their parents have often told them how difficult it was to find a formula or many foods which agreed and that they as infants were poor sleepers and poor eaters of green vegetables.

Even before colic a symptom not infrequently occurs which to my mind is the earliest recognizable prenatal allergy. That sign or symptom is hiccup in the unborn child. It can be palpated and heard with a stethoscope whenever it occurs. In a series of 21 such cases reported by me in 1942, five of the mothers could be fed a certain specific food and within a few hours their unborn infant could be detected as having hiccups. This has been repeatedly confirmed by many obstetricians.

Whenever there is a case of fetal hiccups, the obstetrician should inform the pediatrician that the infant to be, will, in all probability, be difficult to feed. By the time he is eight or 10 years old, he will have a definite type of allergy.

Likewise, the hindsight ascertained by studying allergic adults tells of the importance of early infantile symptoms such as colic or eczema. Conversely, when one is confronted with infants who have an allergic history, he can visualize adults later with some type of allergic problem.

It is a well known observation that in about one third to one half of the infants with allergic eczema asthma develops in later childhood, or in adult life. In addition, I believe that in infants who have severe colic or cry often, or those who have much feeding difficulty, there develops later a respiratory or gastrointestinal type of allergy.

Thus by earlier recognition of potential allergy, one is in a good position to ameliorate its effects and possibly to remove the allergic tendency. It must be remembered that time spent in questioning and listening to patients or parents is well worth while and enables one to give his patients better results.

Testing

Once the patient is labeled as allergic, it is necessary to resort to skin tests for additional clues. In addition to the history, the results of skin tests enable one to start the allergic patient on a more feasible dietary regimen for food sensitivity, and an antigen, when indicated, for inhalant factors.

Skin tests are far from perfect, but despite their limitations they are vastly superior to elimination diets or inhalant antigens based on guesswork alone. No one should claim that skin tests are infallible. Likewise, they do not definitely indicate clinical sensitivity simply because the test gives positive results. All the information obtained is an indication of past, present, or future sensitivity. The tests should be correlated with the detailed history. After a food is withdrawn for a minimum of six months, one is then in a position to see whether there is a definite reaction when the food is retried. If it causes any untoward symptoms from the moment it is eaten to a few days later, it should be avoided again for some six months as no tolerance has been built up. If no symptoms appear when a formerly forbidden food is retried, their absence, within reason, indicates no present sensitivity. For the next six months that food should be eaten at intervals of about three to four days to avoid losing the tolerance built up.

The greater reliability of inhalants to foods in giving positive reactions is well accepted by allergists.

To avoid any possibility of a reaction from skin tests, it is wiser and safer to make intracutaneous tests only after reaction to similar tests by the scratch method has proved negative. Likewise, it is far safer to avoid direct testing when constitutional reactions are feared, as with those who have recurrent severe urticaria or angioedema, generalized eczema or pronounced dermographia. For those with skin allergy, I believe it is unwise, besides not being devoid of danger or reactions, to test directly. The skin in such cases is usually far too sensitive to be tested, and to my mind it is like sowing seeds in a soil that one knows is the wrong type of earth. Also, to avoid local or general reactions and too many false positive results, skin testing should not be carried out in two or three days, but should be spread over a period of two or more weeks.

For infants or little children I have used passive transfer testing for 17 years. That method does not upset the little fellows' morale as does direct testing, even though the technician might be most skillful. Results in my hands have certainly proved that method worth while in a substantial majority of children.

In addition to use with children, I find the passive transfer method of value in all types of skin allergy, for those who have much dermographia, for those unable to visit an allergist and stay long enough for adequate skin testing, and for those who have a chronic asthma requiring the uninterrupted use of epinephrine hydrochloride.

Early recognition of potential or real allergy is the best means, at present, of reducing the severity and recurrence of symptoms. To reduce the danger of sensitivity in infants allergic to inhalants or those born of highly allergic parents, the room should be as dust-free as possible. Animal and fowl pets should not be permitted even though the psychology of a child and a pet is such a good factor. Insect sprays which contain pyrethrum (and it is in practically all insect sprays) should not be used around allergic infants and children. Skin testing is a necessary factor for additional clues. The method of choice of necessity varies with different ages and conditions, especially among little children and in cases of skin allergy. The time spent in eliciting a history or in obtaining interval notes during each visit is most valuable and is so necessary.

Summary

The pediatrician is the key man in reducing the incidence and severity of allergic disorders. He will be well rewarded for the time spent in questioning the parents and listening to them. A regular routine of introducing single foods slowly and with an interval first of five then three days will enable the pediatrician to recognize allergic signals as they arise. The avoidance of offending foods as soon as they are discovered helps to overcome symptoms and avoid multiple sensitivity. An environment as dust-free as possible and free of animals and pets is helpful in avoiding inhalant sensitivity. Allergic diets should be in writing and should include needed minerals and multiple all synthetic, water-soluble vitamins.

The practice of good pediatric allergy offers much hope for the reduction of future allergic problems of adults. It is really an example of a "stitch in time saves nine."

218 Lakeview Avenue.

ABSTRACTS OF MEDICAL ARTICLES

Allergy from the Otolaryngologist's Viewpoint. By Frederick D. Droege, M.D., F.A.C.A. Ann. Allergy 10:288-290 (May-June) 1952.

Observing that a working knowledge of the role played by allergy in the practice of otolaryngology is of major importance to the physician and the patient, the author discusses allergy from the viewpoint of an otolaryngologist. He notes that many patients with external otitis or so-called fungus of the ear, who responded poorly to usual treatments, have been shown by allergic tests to exhibit positive sensitivities. Frequently also in cases of blocked ears, tinnitus, nasal symptoms, cough, colds, sinus complaints referable to the throat such as nonspecific pharyngitis, and those requiring endoscopy, hypersensitivities can be demonstrated when examination otherwise reveals nothing significant. In such instance, he concludes, the nasal smear and the microscopic examination of secretions are valuable diagnostic aids.

Factors Influencing Cerebral Blood Flow and Metabolism, A Review. By Peritz Scheinberg, M.D., and Harold W. Jayne, M.D. Circulation 5:225-236 (Feb.) 1952.

The authors review the results of studies utilizing the nitrous oxide technic for measuring cerebral blood flow and divide them into three groups: (1) those in which cerebral blood flow and metabolism were normal, (2) those in which cerebral blood flow was increased, and (3) those in which cerebral blood flow and metabolism were decreased. They also review and discuss the factors which apparently regulate and control cerebral blood flow and metabolism.

In summary, they state that the regulation of cerebral blood flow and metabolism is accomplished by a variety of complex mechanisms, all of which appear to operate interdependently. These factors include the arterial pressure head, blood viscosity, cerebral venous tone, intracranial pressure, degree of cerebral vascular occlusion, blood pH, blood oxygen and carbon dioxide content, and local cerebral tissue requirements. Investigation of these mechanisms enhances knowledge of many diseases affecting the brain and makes approach to their therapy more rational. Changes in mental status, if characterized by an alteration in the level of awareness of the patient, are usually accompanied by a decrease in cerebral metabolism; however, changes in mental function and great alterations in behavior pattern of a patient, such as in schizophrenia, are not necessarily related to abnormal cerebral metabolism. The causes for this type of mental aberration remain to be discovered.

As the concluding observation states, the great potentialities of any investigative procedure which permits inquiry into the intricacies of mental function are obvious, as is the eventual value of these investigations to the clinician in his handling of patients. The article has a comprehensive bibliography.

The Carotid Sinus, Its Clinical Importance. By Elwyn Evans, M.D. J. A. M. A. 149:46-50 (May 3) 1952.

In this comprehensive study, the author discusses the clinical importance of the hyperactive carotid sinus reflex and carotid sinus syncope. He also discusses 20 cases of the carotid sinus syndrome, 1 possible carotid sinus syndrome and 2 cases of the hyperactive carotid sinus reflex. He considers the carotid sinus syndrome an important disease commonly overlooked, which should be suspected in all patients with dizziness, faintness, syncope, or convulsions, although it is predominantly a disease of men in the upper age brackets.

Emotional states, such as anxiety or worry, and fatigue are usually associated with exacerbations of symptoms in the vagal as well as in the cerebral and mixed forms of carotid sinus syncope. Dr. Evans also observes that the carotid sinus may not be found to be hyperactive on pressure during periods when the patient is without symptoms. Family histories suggest a familial tendency, and other diseases, particularly coronary or cerebrovascular disease, are usually present. The prognosis depends mainly on these diseases. In addition, complicating diseases, such as the neurovascular syndrome, Ménière's disease, narcolepsy and cataplexy in this series, may make diagnosis seem more difficult and prognosis seem more serious.

In most cases response to medical management is good, but occasionally surgery is necessary. Banthine (beta-diethylaminoethyl xanthene-9-carboxylate) apparently was clinically effective in the 6 cases in which it was used.

Iodism. By Thomas M. Irwin, M.D. Ann. Otol., Rhin. & Laryng. 61:408-435 (June) 1952.

In this successful candidate's thesis presented to the American Laryngological, Rhinological & Otological Society, Dr. Irwin discusses the therapeutic uses of iodine, the effect of this drug on various body tissues, the significant role of iodized oils as contrast mediums in roentgen diagnosis, and idiosyncrasies to iodinated compounds resulting in iodism. After presenting the general manifestations of iodism with respect to the skin and mucous membranes of the body, he describes the deleterious effect of iodinated compounds upon the respiratory tract, the gastrointestinal tract, and the glandular organs of both internal and external secretion. He also outlines the precautions to be taken in the use of iodides and iodized oils, the contraindications to their use, and the treatment of iodism in the acute stage.

Included is a review of the literature on iodism, dealing particularly with iodism in bronchography, but also in association with other diagnostic measures, such as myelography, arteriography and urography, and with iodine therapy.

In the fatal case of severe acute iodism reported, iodochlorol was employed in the course of a bronchoscopic examination. This case, with autopsy, illustrates well the complications which may arise for it presents most of those known to occur, including edema of the glottis, iododerma and exacerbation of chronic glomerulonephritis. It serves to emphasize the risk involved in the occasional case, particularly in the presence of renal damage.

It is concluded that the use of iodinated compounds may be contraindicated in bronchography and other diagnostic procedures, as well as therapeutically, when pre-existing renal involvement is present.

FLORIDA MEDICAL ASSOCIATION

OFFICERS AND COMMITTEES

OFFICERS

ROBERT B. MCIVER, M.D., President..... *Jacksonville*
FREDERICK K. HERPEL, M.D., Pres.-elect..*West Palm Beach*
FRANCIS H. LANGLEY, M.D., 1st Vice Pres...*St. Petersburg*
ERASMUS B. HARDEE, M.D., 2nd Vice Pres.....*Vero Beach*
H. QUILLIAN JONES, M.D., 3rd Vice Pres.....*Fort Myers*
SAMUEL M. DAY, M.D., Sec'y-Treas.....*Jacksonville*
SHALER RICHARDSON, M.D., Editor.....*Jacksonville*

MANAGING DIRECTOR

STEWART G. THOMPSON, D.P.H.....*Jacksonville*
ERNEST R. GIBSON, Assistant.....*Jacksonville*

BOARD OF GOVERNORS*

ROBERT B. MCIVER, M.D., Chm...(Ex Officio) .*Jacksonville*
JAMES L. BORLAND, M.D...AL-53.....*Jacksonville*
DUNCAN T. MCEWAN, M.D...B-53.....*Orlando*
JAMES H. POUND, M.D...A-54.....*Tallahassee*
NORVAL M. MARR, M.D...C-55.....*St. Petersburg*
JOHN D. MILTON, M.D...D-56.....*Miami*
HERBERT E. WHITE, M.D...PP-53.....*St. Augustine*
DAVID R. MURPHEY, JR., M.D...PP-54.....*Tampa*
FREDERICK K. HERPEL, M.D. (Ex Officio).*W. Palm Beach*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*
HERBERT L. BRYANS, M.D...S.B.H.-53.....*Pensacola*
STEWART G. THOMPSON, D.P.H. (Advisory)...*Jacksonville*

*SUB-COMMITTEES

1. Veterans Care
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
GEORGE M. STUBBS, M.D.....*Jacksonville*
DOUGLAS D. MARTIN, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

2. Advisory to National Foundation Infantile Paralysis
FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
H. PHILLIP HAMPTON, M.D.....*Tampa*
ROBERT P. KEISER, M.D.....*Coral Gables*
RICHARD G. SKINNER, JR., M.D.....*Jacksonville*

3. Review of Fee Schedules
JOHN D. MILTON, M.D., Chm.....*Miami*
WOODROW B. ESTES, M.D.,.....*St. Petersburg*
FREDERICK H. BOWEN, M.D.....*Jacksonville*
ODIS G. KENDRICK, JR., M.D.....*Tallahassee*
JAMES B. GLANTON, M.D.....*Orlando*
FLOYD K. HURT, M.D.....*Jacksonville*
HERSCHEL G. COLE, M.D.....*Tampa*
A. FRANKLIN HARRISON, M.D.....*Madison*
JACK O. W. RASH, M.D.....*Miami*
KENNETH S. WHITMER, M.D.....*Miami*
ADELBERT F. SCHIRMER, M.D.....*Orlando*

4. Blue Shield
LEIGH F. ROBINSON, M.D., Chm.....*Fort Lauderdale*

SCIENTIFIC WORK

JAMES N. PATTERSON, M.D., Chm...AL-53.....*Tampa*
CAROL C. WEBB, M.D...A-53.....*Pensacola*
FREDERICK K. HERPEL, M.D...D-54.....*West Palm Beach*
JERE W. ANNIS, M.D...C-55.....*Lakeland*
RICHARD C. CUMMING, M.D...B-56.....*Ocala*

LEGISLATION AND PUBLIC POLICY

H. PHILLIP HAMPTON, M.D., Chm...B-53.....*Tampa*
WILLIAM M. ROWLETT, M.D...AL-53.....*Tampa*
DANIEL A. MCKINNON, M.D...A-53.....*Marianna*
ANGUS D. GRACE, M.D...C-55.....*Fort Myers*
DONALD W. SMITH, M.D...D-56.....*Miami*
ROBERT B. MCIVER, M.D. (Ex Officio).....*Jacksonville*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*

MEDICAL EDUCATION AND HOSPITALS*

JACK Q. CLEVELAND, M.D., Chm...AL-53.....*Coral Gables*
JULIUS C. DAVIS, M.D...A-53.....*Quincy*
ELBERT MCLAURY, M.D...D-54.....*Hollywood*
S. CARNES HARVARD, M.D...C-55.....*Brooksville*
BENJAMIN F. DICKENS, M.D...B-56.....*Fernandina*

*SPECIAL ASSIGNMENT

1. Urge Gifts to American Medical Education Foundation

PUBLIC RELATIONS*

EUGENE B. MAXWELL, M.D., Chm...AL-53.....*Tampa*
LEIGH F. ROBINSON, M.D...D-53.....*Fort Lauderdale*
HOWARD V. WEEMS, SR., M.D...C-54.....*Sebring*
EUGENE G. PEEK, JR., M.D...B-55.....*Ocala*
HENRY L. SMITH, JR., M.D...A-56.....*Tallahassee*

*SPECIAL ASSIGNMENTS

1. Rural Educational Program
2. State Education Campaign

NECROLOGY

ALVIN L. SIEBBINS, M.D., Chm...A-56.....*Pensacola*
HUGH WEST, M.D...AL-53.....*DeLand*
JOSEPH HALTON, M.D...C-53.....*Sarasota*
WALLACE H. MITCHELL, M.D...D-54.....*Key West*
JOSEPH J. LOWENTHAL, M.D...B-55.....*Jacksonville*

MEDICAL POSTGRADUATE COURSE

TURNER Z. CASON, M.D., Chm...B-55.....*Jacksonville*
ARTHUR J. BUTT, M.D...AL-53.....*Pensacola*
FRANZ H. STEWART, M.D...D-53.....*Miami*
J. BROWN FARRIOR, M.D...C-54.....*Tampa*
FRANCIS T. HOLLAND, M.D...A-56.....*Tallahassee*

CANCER CONTROL

FRAZIER J. PAYTON, M.D., Chm...D-54.....*Miami*
MILTON C. MALONEY, M.D...AL-53.....*Jacksonville*
ROBERT L. TOLLE, M.D...B-53.....*Orlando*
GEORGE W. MORSE, M.D...A-55.....*Pensacola*
WESLEY W. WILSON, M.D...C-56.....*Tampa*

MEDICAL ECONOMICS

REUBEN B. CHRISMAN, JR., M.D., Chm...AL-53....*Miami*
JOHN E. MAINES, JR., M.D...B-53.....*Gainesville*
HARRISON A. WALKER, M.D...D-54.....*Miami*
WILLIAM H. WALTERS, JR., M.D...C-55.....*Lacoochee*
WILLIAM C. ROBERTS, M.D...A-56.....*Panama City*

VENEREAL DISEASE CONTROL

MELVIN M. SIMMONS, M.D., Chm...C-55.....*Sarasota*
JOHN R. BROWNING, M.D...AL-53.....*Jacksonville*
JOHN C. MCSWEEN, JR., M.D...A-53.....*Pensacola*
WILEY M. SAMS, M.D...D-54.....*Miami*
DAVID W. GODDARD, M.D...B-56.....*Daytona Beach*

TUBERCULOSIS AND PUBLIC HEALTH*

RALPH S. SAPPENFIELD, M.D., Chm...AL-53.....*Miami*
PHILLIP W. HORN, M.D...B-53.....*Jacksonville*
ERASMUS B. HARDEE, M.D...D-54.....*Vero Beach*
LOUIS J. GARCIA, M.D...C-55.....*Tampa*
HARRY S. HOWELL, M.D...A-56.....*Lake City*

*SPECIAL ASSIGNMENT

1. Diabetes Control

STATE CONTROLLED MEDICAL INSTITUTIONS

William D. Rogers, M.D., Chm...A-56....*Chattahoochee*
James L. Anderson, M.D...AL-53.....*Miami*
Bailey B. Sory, Jr., M.D...D-53.....*Palm Beach*
James G. Lyerly, M.D...B-54.....*Jacksonville*
Samuel G. Hibbs, M.D...C-55.....*Tampa*

MATERNAL WELFARE

F. Frank McCall, M.D., Chm...B-56.....*Jacksonville*
T. Bert Fletcher, Jr., M.D...AL-53.....*Tallahassee*
Lowrie W. Blake, M.D...C-53.....*Bradenton*
John N. Sims, Sr., M.D...A-54.....*Live Oak*
Ralph W. Jack, M.D...D-55.....*Miami*

CHILD HEALTH

Luther W. Holloway, M.D., Chm...B-53....*Jacksonville*
James R. Boulware, Jr., M.D...AL-53.....*Lakeland*
Warren W. Quillian, M.D...D-54.....*Coral Gables*
Daniel F. H. Murphey, M.D...C-55.....*St. Petersburg*
Courtland D. Whitaker, M.D...A-56.....*Marianna*

CONSERVATION OF VISION

Ralph N. Greene, Jr., M.D., Chm...AL-53..*Jacksonville*
William Y. Sayad, M.D...D-53.....*West Palm Beach*
Sherman B. Forbes, M.D...C-54.....*Tampa*
G. Taylor Gwathmey, M.D...B-55.....*Orlando*
Mozart A. Lischkoff, M.D...A-56.....*Pensacola*

ADVISORY TO WOMAN'S AUXILIARY

C. Robert DeArmas, M.D., Chm...B-55....*Daytona Beach*
Benjamin H. Sullivan, M.D...AL-53.....*St. Petersburg*
Edward F. Shaver, M.D...C-53.....*Tampa*
James L. Anderson, M.D...D-54.....*Miami*
Taylor W. Griffin, M.D...A-56.....*Quincy*

REPRESENTATIVES TO INDUSTRIAL COUNCIL*

Charles R. Burbacher, M.D., Chm...D-55..*Coral Gables*
Fred H. Albee, Jr., M.D...AL-53.....*Orlando*
G. Frederick Oetjen, M.D...B-53.....*Jacksonville*
Chas. L. Farrington, M.D...C-54.....*St. Petersburg*
[illegible] Sharp, M.D...A-56.....*Pensacola*

*SPECIAL ASSIGNMENT

1 *Industrial Health*

COUNCILOR DISTRICTS AND COUNCIL

Eugene G. Peek, Jr., M.D., Chm...AL-53.....*Ocala*
First—Francis M. Watson, M.D...1-54.....*Marianna*
Second—Benjamin A. Wilkinson, M.D...2-53.*Tallahassee*
Third—William C. Thomas, Jr., M.D...3-54..*Gainesville*
Fourth—Eugene L. Jewett, M.D...4-53.....*Orlando*
Fifth—Hugh G. Reaves, M.D...5-53.....*Sarasota*
Sixth—Emmett E. Martin, M.D...6-54.....*Haines City*
Seventh—Erasmus B. Hardee, M.D...7-54....*Vero Beach*
Eighth—Donald W. Smith, M.D...8-53.....*Miami*

GRIEVANCE COMMITTEE

Walter C. Payne, M.D., Chm.....*Pensacola*
David R. Murphey, Jr., M.D.....*Tampa*
Herbert E. White, M.D.....*St. Augustine*
Joseph S. Stewart, M.D.....*Miami*
William C. Thomas, Sr., M.D.....*Gainesville*

ADVISORY TO SELECTIVE SERVICE FOR PHYSICIANS AND ALLIED SPECIALISTS

J. Rocher Chappell, M.D., Chm.....*Orlando*
Thomas H. Bates, M.D...“A”.....*Lake City*
Frank L. Fort, M.D...“B”.....*Jacksonville*
Alvin L. Mills, M.D...“C”.....*St. Petersburg*
John D. Milton, M.D...“D”.....*Miami*

EMERGENCY MEDICAL SERVICE

James V. Freeman, M.D., Chm.....*Jacksonville*
Merritt R. Clements, M.D...“A”.....*Tallahassee*
Vernon A. Lockwood, M.D...“B”.....*St. Augustine*
Herschel G. Cole, M.D...“C”.....*Tampa*
Frederick K. Herpel, M.D...“D”.....*West Palm Beach*

A.M.A. HOUSE OF DELEGATES

Louis M. Orr, II, M.D., Delegate.....*Orlando*
Joshua C. Dickinson, M.D., Alternate.....*Tampa*
(Terms expire Dec. 31, 1953)

Reuben B. Chrisman, Jr., M.D., Delegate.....*Miami*
Frank D. Gray, M.D., Alternate.....*Orlando*
(Terms expire Dec. 31, 1954)

Herbert L. Bryans, M.D., Delegate.....*Pensacola*
Thomas H. Bates, M. D., Alternate.....*Lake City*
(Terms expire Dec. 31, 1954)

BOARD OF PAST PRESIDENTS

William E. Ross, M.D., 1919.....*Jacksonville*
H. Marshall Taylor, M.D., 1923.....*Jacksonville*
John C. Vinson, M.D., 1924.....*Fort Myers*
John S. McEwan, M.D., 1925.....*Orlando*
H. Mason Smith, M.D., 1926.....*Tampa*
John A. Simmons, M.D., 1927.....*Arcadia*
Frederick J. Waas, M.D., 1928.....*Jacksonville*
Julius C. Davis, M.D., 1930.....*Quincy*
William M. Rowlett, M.D., Chm., 1933.....*Tampa*
Homer L. Pearson, Jr., M.D., 1934.....*Miami*
Herbert L. Bryans, M.D., 1935.....*Pensacola*
Orion O. Feaster, M.D., 1936.....*Renton, Wash.*
Edward Jelks, M.D., 1937.....*Jacksonville*
Leigh F. Robinson, M.D., 1939.....*Fort Lauderdale*
Walter C. Jones, M.D., 1941.....*Miami*
Eugene G. Peek, Sr., M.D., 1943.....*Ocala*
John R. Boling, M.D., 1944, 1945.....*Tampa*
Shaler Richardson, M.D., 1946.....*Jacksonville*
William C. Thomas, Sr., M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne, M.D., 1949.....*Pensacola*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey, Jr., M.D., Sec'y., 1951.....*Tampa*

From Our President

On to Hollywood
April 26-29

Again it is convention time — that annual period when the members of the Florida Medical Association are privileged to renew acquaintance and enjoy with old friends and new the pleasantries of living. For the sixth time now, delightful, hospitable Hollywood welcomes us. This seventy-ninth annual convention bids fair to be one of the best, and we hope the best, in the Association's long history.

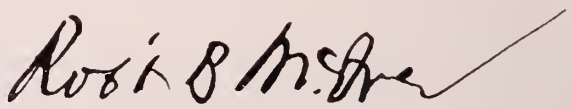
Unusual effort has been put forth to make this gathering a memorable one. The program for the scientific sessions was published in the March issue of The Journal. Have you read it? The papers, presentations and exhibits have been selected with care, and every member should profit by attendance at the various meetings.

This is your convention. It is not just for your officers and delegates. While it marks the consummation of the year's work for those of us who have carried on in official capacity, our efforts, our diligence, our accomplishments have been for you — each and every member of the Association.

The thoughtful cooperation of all is as important as the leadership of the few. Many are the milestones of progress scattered across the seventy-nine years of our society's existence, but, always, greater goals lie ahead. To achieve them requires cooperative endeavor, the interest and the individual effort of the entire membership.

It is my earnest desire that every member realize that he is not only an integral part but also a most important part of this Association. I urge you to fulfil that role by keeping abreast of current issues, attending the annual meeting and making your views on vital questions clearly known.

So, no other business April 26 to 29. Hollywood is calling us all. Do not miss this one — your own convention. I am looking forward to seeing you there. Grant me the privilege of extending to all of you a most hearty welcome.



The Journal of the
Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION

P. O. BOX 1018 JACKSONVILLE, FLORIDA

Editor
Shaler Richardson, M.D.

Assistant Editars
Webster Merritt, M.D.
Franz H. Stewart, M.D.

Associate Editors

Louis M. Orr, II, M.D. Orlando
Joseph J. Lawenthal, M.D. Jacksanville
Jere W. Annis, M.D. Lakelond
Herschel G. Cole, M.D. Tompa
Wilson T. Sowder, M.D. Jacksonville
Carlos P. Lomor, M.D. Miami
Wolter C. Payne, M.D. Pensacala

Managing Editor
Stewart G. Thompson, D.P.H.
Ernest R. Gibson, Asst.

Committee on Publicolion

Shaler Richardsan, M.D., Choirmon Jocksanville
Chas. J. Callins, M.D. Orlando
James N. Patlerson, M.D. Tampa

Abstract Deparlmenl

Kenneth A. Marris, M.D., Chairman Jacksanville
Wolter C. Janes, M.D. Miomi

West Florida
Three Centuries Under Four Flags
Conquest and Disease

The annals of West Florida, that is to say, the history of discoveries and attempts at colonization along the west coast of the Florida peninsula extending north and westward toward and beyond Pensacola Bay, are replete with romance, tragedy, charm, pathos, humor and grief. For bold adventure and bravery amidst untold hardships, this story is unsurpassed. Medical events, largely unchronicled, have proved to be surprisingly important to the over-all development of the region. Loss of men due to illness and death as a result of epidemics, exposure and inadequate food caused missions and attempt at conquest to fail. Thus medical men, virtually unknown to historians, have played important roles in shaping the destiny of "West Florida."

The Narvaez Expedition

Ponce de Leon probably sailed as far west as Pensacola Bay in 1513, but tall, red-bearded, one-eyed Pánfilo de Narváez, granted the title of "Adelantado" by Charles V in 1527, holds the honor of being the first white man to explore a large part of that vast expanse of territory known in the sixteenth century as Florida. In April 1528, he landed in the vicinity of St. Clement's Point on the peninsula west of Tampa Bay near its entrance. Despite the protest of Cabeça de Vaca, prominent member of the group, Narváez sent his ships northwestward along the shore to look for Panuco, Mexico, while he with some 300 followers proceeded in the same general direction on land. Across the Withlacoochee and Suwannee rivers, they reached the Indian town "Appalachee," probably now located in upper Leon or Jefferson County north of Tallahassee, and then proceeded to the village of Auté, in all probability the present site of St. Marks.

Harassed by unfriendly Indians and plagued by illness and hunger, the group set out for the coast without enough horses to carry the sick. Treachery among the horsemen added to their plight, but the adventurers managed to reach one of the little harbors in Appalachee Bay. There, with but one carpenter and no tools, forge, resin or rigging, but with desperation and necessity to spur their flagging energy, the men constructed a forge with bellows made of wooden pipes and deerskins. Stirrups, spurs, crossbows, and virtually every article which contained iron were used to make nails, axes and saws. Fiber from the "fan-palm" was used to caulk the boats. Resin was extracted from pine and oars were hewn from

the juniper trees. Shirts from the men's backs were made into sails. Hair from the tails and manes of the horses was used to make ropes and riggings. Skin stripped from their legs was tanned and made into water bottles, and the flesh from their carcasses was consumed as food. By the time five boats had been built, 40 men had died and only one horse survived.

Having named the harbor Baia de Caballos, the Bay of Horses, and having provisioned the ships with maise taken by force from Indians in the region, 242 survivors, nearly 50 to each boat, not one of whom had any knowledge of navigation, set sail on September 22 of that fateful year, 1528. The poorly constructed boats, laden nearly to the gunwales, must have presented a pitiful picture as they sailed westward into the storms which were prevalent in the Gulf at that time of year. It is surprising that the adventurers got as far as Pensacola Bay. Actually, they seem to have reached a point near the mouth of the Mississippi River where a swift current and strong wind carried the boats beyond sight of land for three days. Narváez and the men in his boat were drowned, but finally one of the boats, in which all had succumbed to exhaustion except Cabeça de Vaca, was cast ashore on the morning of November 6 on a long, narrow island inhabited by savages and located not far from the coast of what was still known to the explorers as Florida, but now actually is Texas. The Spaniards named this land Malhado or "Island of Misfortune," and here Vaca spent a year.

The story of the survivors from the following day, when the arrival of one of the other boats made their number 80, until the arrival of the only four survivors in Mexico, is studded with almost unbelievable incidents. On the island, sick Indians appealed to the white men for assistance, reasoning that since stones and other inert objects supposedly had curative properties, such extraordinary men as these Spaniards must possess power over all things. They insisted that the Spaniards heal their sick and withheld food from them until they should practice medicine as they demanded. Said Cabeça de Vaca:

> At last finding ourselves in great want, we were constrained to obey. . . . Our method was to bless the sick, breathing upon them, and reciting a Pater-Noster and an Ave Maria, praying with all earnestness to God our Lord that He would give help and influence to make us some good return. In His clemency He willed that . . . those for whom we supplicated should . . . say that they were sound and in good health, . . . after we had made the sign of the blessed Cross over them.

In this Vaca and his men appear to have followed the method of some of the Castillian lay healers of Spain, who performed such offices although neither priests nor monks.

After escape from the island, progress toward Mexico was slow. The Christians resumed their treatment of the sick and soon their success, especially that of Cabeça de Vaca, was sounded far and wide among the tribes of natives. Literally thousands of them followed the Spaniards from place to place and showered them with gifts.

A critical study of the narrative as a whole, first published in 1542, and of a translation by Buckingham Smith published in 1871 would seem to indicate that Narváez was an inadequate leader, that the expedition was a dismal failure, and that the adventures of Cabeça de Vaca and his three companions, who, after years of captivity and weary wandering finally reached Mexico, contributed invaluable information concerning North America. Here was the first description of vast sections of the North American continent, of the bison of the western plains, and also an account of the intimate knowledge gained of the savage tribes. The over-all effect of this journey was to inspire other expeditions.

On the question of the general trustworthiness of Vaca's remarkable narrative there is wide divergence of opinion. Many early writers, including Brinton in 1859, believe that the main story of the journey, while accurate, is "disfigured by bold exaggeration" chiefly because of the claims to "wondrous miracles, even to healing the sick and raising the dead." Others, including Lowrey and Hodge, give Vaca more or less full credit.

The chronicler himself, Alvar Nuñez Cabeça de Vaca, seems to have been conscientious and not given to exaggeration. His account of the many strange incidents and adventures which befell him usually is qualified by such statements as "they said they were cured," and for the most part probably can be accepted as reasonably accurate. The marvelous healings for which he and his Spanish companions were given credit made it possible for them eventually to reach Mexico.

Hernando de Soto

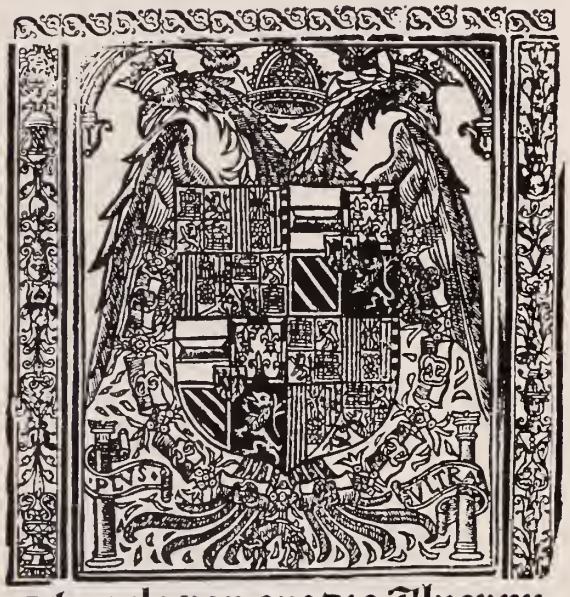
Hernando de Soto, a far greater leader than Narváez, had returned from Peru with great riches and an untarnished reputation. He so ingratiated himself with King Charles V of Spain that that monarch conferred on him the governorship of Cuba and gave him the right to conquer Florida, that is, North America. Vaca's Indian

tales of silver cities and jewelled doors stimulated many Spaniards to follow the Governor and his expedition. Even noblemen sold their estates and joined him. Undaunted by Narváez's failure to discover another Mexico, De Soto dreamed of finding another Peru in the wild region of the great continent called Florida. On Whitsunday, May 25, 1539, he apparently landed at Gadsden's Point, also on Tampa Bay. He named the bay Espiritu Santo for the day on which he reached the coast. Foresighted and well equipped, he had with him 600 men suitably armed, 213 horses, greyhounds to give chase to fugitives, and swine to serve as food. Accompanying him were a surgeon with medicines, priests and Dominican friars, caulkers and a ship's carpenter. With them they brought a portable forge which would serve to repair armour, swords and chains.

Fortunately, soon after the landing, Juan Ortiz of Seville, one of Narváez's men, was found by one of De Soto's captains and pressed into service as a guide and interpreter. He had been enslaved by an Indian chief named Hirrihigua, whose princess-daughter had helped him escape to a rival neighboring cacique.

East, then northwest through the present regions of Ocala and old Micanopy to "Cale" probably near the Suwannee River, the expedition followed essentially the route of Narváez and from the very outset began to be attacked by Indians who had not forgotten the cruelty of the first explorer. After wintering at "Anica Apalache" near the present site of Tallahassee, they apparently went through what is now Georgia and the Carolinas, probably into Tennessee and thence into Alabama, to Mavilla, the town of the Mobilians near the junction of the Tombigbee and Alabama rivers.

De Soto learned from Ortiz that Maldonado, one of his captains who had "discovered" Pensacola Bay, was waiting there with supplies, "approximately a 6 day journey distant." Fearing that his troops, by that time eager to return to Cuba, might mutiny if they learned of Maldonado's proximity, De Soto directed Ortiz not to divulge the information. He also feared that if men from Cuba "should haue newes of him without seeing from Florida . . . gold nor silver, nor anything of value . . . no man would seeke to goe thither when he should have neede of people." After the wounded men had dressed and "healed" their wounds with the fat of slain Indians, De Soto changed the direction of their march to northwest and reached the headwaters of the Yazoo and Mobile rivers in what is now the state of Mississippi. There he wintered. Beginning the journey again in the spring of 1541, he soon reached the mighty Mississippi River at a spot which has remained in sharp dispute to this day. It is



La relacion que dio Alvar nu-
ñez cabeça de vaca de lo acaescido enlas Indias
enla armada donde yua por gouernador p̃
philo de narbaez desde el año de veynt
y siete hasta el año d treynta y seys
que boluio a Seuilla con tres
de su compañia.

Title-page from Alvar Nuñez Cabeza de Vaca, *Relación*, the Zamora Edition (1542)

From "The Pageant of America" Volume I, Adventurers in the Wilderness, by Clark Wissler, Constance Lindsay Skinner and William Wood, New Haven, Conn., Yale University Press, 1925.

thought by many historians that he crossed the great river in the neighborhood of the Lower Chickasaw Bluffs about 15 miles south of the mouth of the St. Francis River. In the more than four centuries which have elapsed since De Soto's famous crossing, the course of the Mississippi has undergone such great changes that the point where the St. Francis empties into it some 80 miles below Memphis may be considerable distance from the original site of the crossing.

It is not possible to trace the wandering of the Spaniards west of the Mississippi. West, north, and south into areas which probably are now Arkansas and Oklahoma, they made their way across level country into high mountains. Encountering Indian women who fought with more

determination than the men, they also came upon a strange tribe with heads unusually long and pointed, a deformity which had been artificially produced in childhood.

While snowbound during the early winter at Antiamque, the expedition lost its faithful interpreter. Juan Ortiz became ill, and his death deprived the men of a skillful interpreter whose task could not be performed adequately by the young Indian understudy named Peter, who had been captured in Georgia.

When De Soto broke up winter quarters in March 1542, he followed the Mississippi southward looking for a port from which he could communicate with Cuba. After many days of unsuccessful exploration among bayous and swamps, under pressure of increasing hardships and disappointments, he became ill with fever. He then appointed Luis de Moscoso his successor and made his will and confession. Death came to De Soto, one of the most indomitable spirits of that era, on May 21, 1542.

Moscoso and his followers, who had led the natives to believe that De Soto was "a child of the sun" and immortal, attempted to perpetuate that belief. Keeping his death secret from the Indians, they buried De Soto's body at night at one of the gates within the town, "Guachoya," and the men pranced their horses over his grave in order to camouflage it. Their fear, however, that the Indians suspected his death and might dig up and mutilate the corpse, as was their custom, led the Spaniards to disinter the body at night. They wrapped it in a mantle weighted with sand, rowed out silently in their canoes and consigned the body of their general to the bed of the great river which he had discovered.

The Spaniards then pushed westward into Texas and came upon "mantles of cotton wool" and stones which they thought were turquoise of the Pueblos in the Rocky Mountains. Suffering from illness and exhaustion, attacked by Indians and misled by guides, Moscoso longed for "a place where hee might sleepe his full sleepe rather than to conquer and gouerne a countrie where so many troubles presented themselves." Accordingly, he returned with his followers to the Mississippi. There, with remarkable ingenuity, they constructed a fleet of seven ships, floated down the river, crossed the Gulf, and reached Mexico in safety. Of the 600 who had landed at Tampa Bay some four years before, 322 survived.

The story of this expedition, now one of the most famous in all history, is a classic of three seemingly independent sources. Related and published in 1557 by a Portuguese citizen called the Gentleman of Elvas, it was first translated and published in English by Hackluyt in 1609. That account is perhaps better and more valuable than the others. The second source is the famous history of Florida by Garcilaso de la Vega, which was completed in 1591 and first published in Lisbon in 1605 under the title "La Florida del Ynca." Having passed through many editions in different languages, it is sometimes referred to as an epic which is easily the first great classic of American history. Perhaps the only adequate rendering of this work in English is the recent translation by John and Jeanette Varner, published in 1951 by the University of Texas Press at Austin. Not an eyewitness of the events which he narrated, Garcilaso de la Vega prepared his work from the written memoirs of two soldiers and the oral report of an officer who took part in the expedition. There has been diversity of opinion as to Garcilaso de la Vega's reliability, and there are scholars who believe that his account is exaggerated, his style bombastic, and his conclusions uncritical.

The third source exists in the form of a report presented to Charles V of Spain in 1544 by Luis Hernandez de Biedma, which may be found in the Historical Collections of Louisiana published in Philadelphia in 1850, and in Rye's reprint of Hackluyt's translation of the Portuguese narrative, published in London in 1851.

The results of De Soto's exploration were altogether different from those which the glowing accounts of Cabeça de Vaca had led the adventurers to expect. The pearls which De Soto's chroniclers described in extravagant terms were of relatively little value since most of them had been pierced or discolored by fire. Finding no gold, the men were not interested in the vast expanse of fertile lands which they discovered. Hence, Florida for a while became known to some as the very worst country warmed by the sun — barren, made up of bogs, and abounding with poisonous fruits.

The failure of De Soto's expedition, however, did not discourage adventurers from continuing to apply for the right of conquest in Florida, but Phillip, who was governing Spain during the 1540s, decided upon more peaceful missions by using the monks. The unsuccessful mission and tragic story of Fray Luis in 1549 illustrate the methods used

by the monks, the fine example they set for the natives and their friendly constructive attitude toward them under all circumstances.

Colonization Attempt Fails

In 1559 an attempt was made at colonization in West Florida when Arrelano Tristan de Luna set sail from the port of Vera Cruz on June 11 with a fleet of 13 vessels carrying some 1,500 persons. There were soldiers, women and children, servants, Negro slaves and Florida Indians. With them were 240 horses. The destination of the fleet was the port of "Ichuse" on what is known today as Pensacola Bay, "discovered" by one of De Soto's captains 20 years earlier. After first touching land west of the Apalachicola River, the ships proceeded westward, came to anchor in Bazare's Bay of Filipina, retraced their course to the east and eventually entered Pensacola Bay on August 14. As it was the season of the Vespers of the Ascension of the Queen of the Angels, Luna named the bay Santa María Filipina. He sent a report back to Mexico telling of his success, stating that he intended to colonize and fortify the port and not penetrate the interior until supplies arrived. Unfortunately, the major portion of the supplies, enough to last for a year, was destroyed by a storm which shattered five ships, a galleon and a bark, killing many of the men. This storm, which began on the night of September 19, was so fierce that it was attributed to evil spirits. Men on shore declared that they had seen devils in the air.

After weeks of searching for villages and sources of food, exploring parties returned from the interior with the news that the country was sterile and not inhabited. Another party, sent farther into the interior, found maize, beans and other provisions in a village named Nanipacua, probably in what is now Alabama near the headwaters of the Escambia River. This village, all but deserted, had apparently been partially destroyed and its inhabitants driven away by De Soto and his men two decades earlier. Luna, notified of this discovery during the winter, used supplies which arrived at Pensacola Bay in two ships in November. In the early spring, when all the food had been consumed and he had been suffering from delirium due to fever, he set out with more than 1,000 colonists for Nanipacua, leaving a small force on the coast. The stores in that village also proved inadequate, and soon the colonists were hungry and in dire straits again.

VIRGINIA

richly valued,

By the description of the main land of *Florida*, her next neighbour:

Out of the foure yeeres continuall trauell and discouerie, for aboue one thousand miles East and West, of *Don Ferdinando de Soto*, and sixe hundred able men in his companie.

Wherin are truly obserued the riches and fertilitie of those parts, abounding with things necessarie, pleasant, and profitable for the life of man: with the natures and dispositions of the Inhabitants.

Written by a Portugall gentleman of *Eluas*, emploied in all the action, and translated out of Portugese by Richard Hacklvyt.

AT LONDON

Printed by Felix Kyngston for *Matthew Lownes*, and are to be sold at the signe of the Bishops head in Pauls Churchyard.
1609.

Title page of the Hackluyt English translation of the account of the DeSoto expedition, written in Portuguese by the Gentleman of Elvas and published in 1557.

A little known saga is the story of the deprivation: how the soldiers were reduced to eating acorns, ground and soaked first in salt water and then in fresh to extract the bitterness; how the women and children who could not stomach this food searched for leaves and twigs of trees, likewise inadequate for their needs; how some were poisoned by the grasses which they ate; how others died of starvation; how they gave great thanks to God when in June they feasted upon nuts from chestnut and walnut trees; how after 50 days more of marching the almost naked soldiers reached an Indian town probably located in what is now Coosa County, Alabama, near Hatchet Creek where they were tricked by Indians; how finally the remainder of the men who had survived sickness and famine

returned to Pensacola Bay only to find that the vicar and two remaining monks had set sail for Havana; how further hardship, lack of occupation and disappointment over not receiving supplies soon produced widespread discontent and made almost all eager to give up their original purpose; how Angel de Villafane was appointed to supercede Luna; how most of the colonists were rescued; how Luna and then Villafane departed for Havana, and Pensacola was abandoned. There is no written record which indicates that an attempt was made to establish a colony on Pensacola Bay.

Almost half a century had elapsed since the discovery of Florida. The Spaniards had pushed their exploration vigorously and boldly, but they had continued to search for gold, had disdained agricultural pursuits, and by stripping the natives of their harvests and treating them cruelly had gained their animosity. Thus the forces of nature favored the Indians. All attempts at colonization failed until Menéndez de Avilés founded St. Augustine in East Florida in 1565 and established the first permanent stronghold on territory which is now the United States.

French Intrusion

In 1683, La Salle left Canada with a French force and traversed the length of the Mississippi to the Gulf in canoes. After returning to France, he organized an expedition which sailed into the Gulf and planted a colony probably located in what is now the state of Texas. As a result of this French intrusion, the Spaniards, Barroto and Romero, while on an expedition in search of La Salle's colony, rediscovered Pensacola Bay in 1686. The natural advantages of this bay impressed them as far superior to those of Mobile Bay, the old Bay of Espiritu Santo. Juan Jordan, the diarist of that expedition, declared it "the best bay I have ever seen in my life."

Andrés de Pez, leader of three of the voyages made in search of the French colony, is most intimately associated with the early movement for Spanish occupation of Pensacola Bay. This movement followed discovery of the ruined settlement of La Salle and knowledge that France had begun attempts to secure a foothold on the mainland bordering the Gulf. Pez, by his persistent efforts, aroused the interest of Spain in the project and usually is considered the originator of the movement which resulted in the occupation of the bay and the founding of Pensacola.

Owing to continued opposition by the Junta de Guerra to the establishment of a colony there, King Charles II adopted an unusual course of action. He concurred in the opinion that a plan proposed by Pez should be carried out except for that part which called for the abandonment of St. Augustine, but he delayed the formal cedula until June 26, 1692, issuing it at that time in a modified form.

Dr. Cárlos de Siguenza y Gongora, professor of mathematics in the Royal University of Mexico and probably the most brilliant scholar and outstanding scientist in the New Spain of that day, was selected by the Viceroy of Mexico to accompany and assist Pez. Siguenza's journal is sufficient testimony to his ability as a scholar and is the authority for the events of the expedition, which was made in 1693. Twenty days were spent in the bay, and it was formally rechristened Bahía de Santa María de Galve by adding the cognomen of the viceroy to the holy name of the Virgin.

Despite agreement that the occupation of the bay was highly important, there was disagreement as to the manner in which it should be accomplished. Pez was sent to Spain, but the Junta de Guerra made little effort to see that the recommendations of the royal cedula issued in 1694 were executed. This cedula directed that occupation and fortification of the bay should begin without delay. A year and a half later the Count de Galve stated in a letter that lack of funds would prevent any action and that help would have to come from Spain. In 1696, Galve died, but his letter served to stir up an investigation which also came to naught.

In 1698, reports that Louis XIV was preparing to carry out the old plans of La Salle had the desired effect. The Junta de Guerra decreed on April 19 of that year that establishment of a presidio at Pensacola was the most urgent business of the Spanish Empire. The Viceroy of Mexico called for advice from Andrés de Arriola, who had visited the bay in 1695, and from Siguenza, who had sent previous reports. Advice from the two men was similar; Arriola's suggestions, however, were apparently adopted in preference to those of Siguenza. The estimated cost of the expedition was 39,000 pesos. The chief items were 3 ships, 12 cannon, 200 soldiers, 120 sailors, 9 artillerymen, 3 surgeons, 3 priests, 12 carpenters, 6 bricklayers and 4 smiths, who with their helpers made a total of 357 persons. Arriola was appointed commander-in-chief and governor of the new post

while Francisco Martinez, who had been prominent in expeditions to land which is now in Texas, was given the rank of sergeant-major and was appointed second in command. Recruiting progressed slowly and required special inducements. Even convicts and beggers were accepted for service. Arriola's instructions, dated September 16, directed that the three ships sail directly to "Santa María de Galve, commonly called Pensacola." Delayed by storms, they arrived at the bay on November 21, to find that Capt. Juan Jordan had arrived from Cuba four days previously.

Timber was cut, temporary quarters were erected, and within six days a battery of six guns was in position. The presidio was given the name of San Carlos de Austria. Built of pine logs in the form of a square, 100 varas on each side, with four bastions, it was located on the western side of the entrance to the bay. Because of the swampy nature of "Punta de Siguenza," construction of a fort on the eastern side was found to be impracticable.

Despite Arriola's dissatisfaction with and repeated condemnation of the entire effort, apparently there was no serious thought of abandoning the enterprise. In the face of adverse conditions, with poor and scarce food, a fire of incendiary origin occurred on the night of Jan. 3, 1699. Although discovered just in time to prevent disaster, it destroyed eight buildings, including the chapel, Captain Jordan's quarters and the storehouse of provisions.

The second French invasion of the Gulf region was announced at the entrance to the Bay of Santa María de Galve on Jan. 26, 1699, by the firing of five cannon shots. The French forces, which proved to be those of the Iberville expedition, requested admittance to the bay to gain shelter for the ships, which included a flagship with 58 guns, a second ship with 38, a third with 32 and 2 "ketches" with 6 guns each. Arriola in very polite language denied their request on the ground that the King had ordered that no foreign vessel be allowed to enter the bay, but offered to have his men help them find a good place to anchor and assist them in refueling the ships. Upon the departure of the French, a council was held by the Spaniards, for it was clear that the French had come to found a colony. Arriola sailed for Mexico on February 2 to appeal for reinforcements. Arriving at an unpropitious time, however, he had difficulty in obtaining 100 additional men to replace those who had died or become unfit for service at the bay. The viceroy ordered that men be conscripted from the gambling houses and jails, but several months elapsed before these orders were carried out.

Much to his disappointment, Arriola was reappointed and ordered to make another extensive exploration of the Gulf region. Later that year it was learned that the French had visited Mobile Bay, and Panzacolas Indians brought news that indicated the English were attempting a settlement on the Gulf coast. Conditions at the bay gradually became more critical. Many died because of lack of proper medical attention. A few went stark mad as a result of adverse conditions. Some 80 sick and dying men were placed on board a vessel and sent to Vera Cruz. By summer, the men at Pensacola were forced to supplement their rations with roots and acorns, a necessity which tended to increase the amount of sickness. Another ship laden with patients was sent to Mexico under the charge of Captain Jordan.

Not until November did Arriola complete his arrangements for return to Florida, and after arriving he was not successful in carrying out orders to attack the new English settlement until the following spring. By that time, disease and desertion had further reduced his ranks. Overtaking a small boat flying the English flag, the Spaniards found the men to be French and thus revealed the hoax that had been perpetrated. They told Arriola that the French had a fort called Biloxi and that they had a second and third fort up the Mississippi River in direct communication with Canada. Obviously it would have been unwise to attack the French. As the Spanish vessels attempted to return to the bay, a storm destroyed all but one of them, but most of the men were saved. After days of untold suffering, the survivors made their way back to the French and were received and treated with kindness and hospitality until Spanish vessels could be obtained to carry them back to the presidio.

By this time, the chief desire of the Spanish garrison was to be allowed to leave and give up their presidio. The viceregal government, however, decided to await the pleasure of the King. Arriola was given a furlough. Martinez was placed in command, and supplies were ordered sent to the presidio. Thus the greatly discontented troops were forced to continue in their unhappy state.

The Name Pensacola

The word Pensacola, name of the bay as well as the city located on that large inlet of the Gulf, had variations of spelling during the early years of history in that region, such as Pensacolas (1699), Pansacolas (1701), Pençocolas (1723), and Pensicola (1741). At least one authority believes that the word is a variation in spelling of the fortified little Spanish seaport named Peniscola, located on the Mediterranean. Several others believe that the name Pensacola is a derivative of the Choctaw Indian words *panshi,* meaning hair, and *okla,* meaning people, the name applied to an early Indian tribe in which the men, as well as the women, wore long hair.

Soon after the founding of Pensacola, there was a general feeling of amity between Spain, governed by Phillip V, and France, ruled by Louis XIV, for these two monarchs were relatives in the House of Bourbon and allies in the War of the Spanish Secession against England. The Spanish and French fighting together repulsed England's attempt to storm Fort San Carlos in Pensacola. The Treaty of Utrecht ended the War of the Spanish Secession, and in 1715 Spain, under Phillip V, waged war against France and England.

In 1718 the Spanish built a fort at St. Marks, and the following year established an outpost at the mouth of the Apalachicola River. The Spanish, however, surrendered to the French in 1719, and Pensacola knew its first real exchange of flags when the banner of France was raised. In 1720 a treaty of peace was signed between France and Spain, and in 1723 Bienville restored Pensacola to the Spanish.

In the years that followed war raged between the North American colonists of England and France. The French gradually lost many of their posts to the British, who garrisoned them with troops. Spain, having allied herself with France, suffered losses also. Pensacola seems to have escaped most of this conflict. The most serious disaster which befell it in the mid-eighteenth century was a hurricane in 1754, which virtually destroyed the place and killed many persons. At that time the town was on the island. Following the storm, the Spaniards built on the mainland. They erected a post of 40 huts surrounded by a stockade on the approximate site of Pensacola today.

Finally, the three belligerent powers concluded a treaty of peace which was ratified at Paris in 1763, whereby France surrendered all of her North American possessions. But before this treaty was ratified, France made a secret treaty with Spain whereby territory on the west side of the Mississippi River, from source to mouth, as well as the island of New Orleans, lying on the east side of the river south of the Bayou Iberville, was ceded to Spain.

English Rule

By the treaty of Paris, England acquired, except for New Orleans, all of Florida east of the Mississippi River, and divided it into East and West Florida. The definition of the boundaries of West Florida during the years of the English rule included a large portion of territory which today is part of Alabama and Mississippi. Including Pensacola, Mobile, and soon Campbelltown, this province was bounded on the east by the Apalachicola River, on the west by Lake Ponchartrain and the Iberville and Mississippi rivers, and on the north by the thirty-first degree parallel.

The few records which are available prior to the British period give virtually no medical data. Soon after the treaty had been ratified, almost the entire Spanish population of West Florida made immediate plans to leave. Of the 772 persons enumerated, there was only one surgeon. By late fall of 1763, evacuation had been so complete that only one Spaniard remained at Pensacola. He was the custodian of cargo in a sloop which had gone aground on the coast.

Major General William Keppel, acting in accordance with the twentieth article of the Treaty of Paris, ordered Lt. Col. Augustin Prevost, of the Royal American Regiment, to occupy Pensacola. He arrived on August 6 and took charge of the post on that day. Prevost and other officers described Pensacola as a village consisting of about 100 huts encircled by a stockade, and situated on the northern shore of its very large harbor, approximately 10 miles from the sea. He wrote further:

> The country from the insuperable laziness of the Spaniards remains still uncultivated . . . but years and a number of industrious settlers can . . . make a change . . . Game is extremely plenty in the woods, and the sea supplies quantities of fish. . . .

Major William Forbes, who arrived with the Thirty-Fifth Regiment on November 30, commented on the dilapidation of the fort and the inadequacy of barracks composed of "bark huts without any sort of fire places or windows, void of every necessary utensil. . . ."

The following year an English officer traveling through the province remarked:

. . . On Monday afternoon [August 20, 1764] came to an Anchor about two Miles off of Pensacola Fort and Village, in five fathom of water.—

The Fort is an Oblong Square with a double Stockade and a very narrow Ditch dug in the Sand. Four Bastions are intended.—The Governour's is the only tolerable House in the place.—It is covered with Shingles, and has a Balcony both ways up one pair of Stairs.—All the other Houses are on the ground, and covered with Palmetto Leaves.—It is a very poor place. . . .

The Garrison is supplied with very good and Wholesome water, from a little river which surrounds the place. . . .

The Bay is magnificent and might contain any Fleet was it not for the want of Water at the Bar. . . .

An Island called Santa Rosa forms the Mouth of the Harbour, and on it stands a trifling little Fort. . . .

This Island has no Springs and in bad Weather the little Garrison . . . has been distressed both for fresh Water and provisions.

At Pensacola they have no fresh meat. . . . Fish I never saw in more abundance. . . . The heat here is much less intense than at Jamaica and the Leeward Islands for there comes almost a daily breeze from the Sea. . . .

Another British officer two years later, in 1776, had this to say of the village:

On Entring the Fort I was Astonished to see the poor Huts that are in it; but much more so when viewing the Condition of them, and that of the "Poor Soldiers" who inhabit here. Their Barracks are covered with Bark on the Sides and Roof, which naturely Shrivels in a short time by the heat of the Sun, which was the case now. The Firmament appeared thro' the Top and on all sides. The Men were walking About like Ghosts on a damp Sandy Floor, that is near a Foot under the Level. They were repairing the Roofs, but this has been the Bane of Cost, and but a short Time serving as a Cover . . .; Some of the Officers Huts were Similar, only the difference of a few Boards laid over the sand to tread on, . . .; The Hospital has only the distinction of always being first Covered, and the Provision Stores that of being the last.

In the English Period. Published in the Gentleman's Magazine, London, 1777.

A North View of Pensacola on the Island of Santa Rosa. — Drawn by Dom Serres.

1—The Fort 2—The Church 3—The Governor's House 4—The Commandant's House 5—A Well 6—A Bungo
After the village was destroyed by a hurricane in 1754, it was relocated on the mainland.

From "Historical Sketches of Colonial Florida" by Richard L. Campbell, Cleveland, O., The Williams Publishing Co., 1892.

The health of the people, the plight of the region, and the availability of medical supplies are given varying emphasis, depending upon the purpose and objective of the writer. For instance, in 1763 when Captain Jon Harries wished to obtain more adequate medical supplies for Pensacola, he wrote to General Amherst as follows:

> The sickness amongst the men has exhausted the greatest part of the few medicines allowed me at St. Augustine, I have now eight men in the flux and one scorbutick. . . . I dread agues in the spring, so medicines will be now much wanted, particularly rhubarb and bark.

The bark to which he refers is "Jesuit's Bark," of the cinchona tree in South America from which quinine was isolated some 50 years later. The bark had proved long before to be effectual in treating "remittant fever," today known as malaria.

A report from Pensacola during the fall of the following year mentioned the evil consequences to the regiment of "inveterate scurvys which terminate in mortification and death" and spoke of the total lack of vegetables. Most reports from Pensacola, however, appear to play up the healthful aspects of the climate and to play down illnesses in order to attract new settlers.

The year 1764 appears to have marked the appearance of the dreaded yellow fever in the province, but there is no record of the severity of the illnesses or the number of people who were afflicted. Many early writers, however, referred to 1765 as the year of severe widespread illness. One hundred twenty-five deaths were reported in Pensacola alone as the result of yellow fever, while Mobile also fared badly. The Twenty-First British Regiment brought the disease from Jamaica, and upon arrival of these troops in Mobile, imprudent officers and soldiers reportedly rioted in intemperance and drank water from stagnant pools until virtually all of them died. Pensacola made a good recovery and was soon noted for its good climate and healthy populace. Mobile, however, had another severe epidemic in 1766, which was especially fatal to newcomers. Many troops were withdrawn, and Mobile's growth was retarded for years.

Captain George Johnstone of the Royal Navy was the first British Governor of West Florida. He brought with him to Pensacola, the seat of government, a British regiment and many Highlanders from New York and Charleston.

The first assembly of the province was convoked on Nov. 3, 1765, in Pensacola in a house hired for the purpose by the government. Pensacola and Mobile were alloted equal representation, each having six members, and Campbelltown had two representatives. The greatest problem of the colony was provision of necessary fortification and protection against Indian raids and possible conquest by a European power. The estimate of fortifications included such items pertaining to governmental equipment and public welfare as the sum of 10,000 pounds sterling to be expended by the Crown for the erection of public houses, the Governor's house, courts, council chambers, assembly chambers and a jail. The establishment of public hospitals, saw mills, and naval arsenals and yard was requested, at an estimated expense of 20,000 pounds sterling. It was pointed out that "to see the Fortifications, Churches, Hospitals and Public Buildings, which are everywhere erecting on the Spanish Dominions . . . whilst nothing is undertaken on our part is extreamly mortifying to those who consider the changeful State of European Powers."

On June 2, 1766, the Assembly passed an act to provide for the cleaning of the streets of Pensacola and to prevent nuisances in and about the town. The act appointed washing places at the west end of town and at the south front of Garden Lot Number 157 in the east end of town.

Attempts to form a colonial legislature, however, were ineffectual, and military government for the most part was retained in the province. Dissatisfied with Governor Johnstone, the colonists caused him to be replaced on Dec. 17, 1766 by the Honorable Montefort Brown, who served in the capacity of lieutenant governor.

General Haldemand made a report on April 31, 1767 to General Gage stating that the water at Pensacola was bad, and that he was issuing rum to the men at the doctor's suggestion, but Gage disapproved of this plan. Instead of rum, spruce beer was manufactured after that time.

On Feb. 1, 1768, Brown wrote to the lords of trade that he had been advised to drink bath water, and he was therefore compelled to ask for six months leave in England. He was replaced by Governor John Elliott, whose somewhat mysterious death occurred soon after his arrival at his post. Between April third and twenty-eighth the minutes of the Council record seven meetings over which Governor Elliott presided. One must rely, in lieu of the evidence, upon the Lieutenant Governor's statement that Elliott died on May second.

A meeting of the Council was called by Lieutenant Governor Brown on the third of that month, at which "His Honor acquainted the council that in consequence of the Sudden Death of his Excellency Governor Elliott yesterday morning that the administration of the Government did Devolve upon him. . . ."

The circumstances of Elliott's death apparently are unknown. It might have been caused by malaria or yellow fever, by an accident, or even by factional strife in the colony eventuating in a duel which all parties found it expedient to conceal. The manner of his death would obviously make considerable difference in the interpretation of the events surrounding it, but with no further information at hand, one is helpless.

At a meeting in June, the Assembly authorized a sum spent for charitable purposes, including a gift to the local hospital at Pensacola. On Jan. 25, 1769, when a new Assembly was called, Dr. John Lorimer was among the members representing Pensacola. In May an epidemic of smallpox broke out. The Lieutenant Governor with the advice of the council issued a proclamation that all poor persons suffering from the disease might apply to the Lieutenant Governor to be taken to Rose Island and there given medicines, provisions, and attendance until their recovery. This service was to be paid for out of the contingency fund.

Near the foot of Gage Hill, an eminence named for the British officer, Pensacola formed "an oblong square" in 1771. Its frame houses, numbering about 180, were "in good taste, and arranged with much convenience." Despite the ravages of storm and flood throughout the province in September 1772, during the early seventies there were evidences of beginning prosperity under the leadership of the universally esteemed Governor Chester. Chief among some 25 exports from Pensacola and Mobile were various kinds of lumber; tobacco, fine cattle and several items of food, notably salted wild beef, dried salt fish, rice, pecans and oranges.

The siege of Pensacola in 1781 was by no means its first, but it was now to sustain a siege from a combined fleet of those who had alternately taken it from each other, the Spanish and the French. Although not yet fully recovered from a severe hemorrhage, José de Gálvez set sail from Havana in February with a sizable fleet. His successes on the Mississippi and against Mobile led him to attempt the conquest of all West Florida, with Pensacola, the capital of the colony, his main objective. Fortune at first seemed to favor the English, "for scarcely were the Spaniards out of port, than a furious hurricane destroyed almost all their fleet. Four men-of-war, besides many others of different sizes, were engulfed in the sea with all on board." After returning to Havana to repair the loss, Gálvez set out again with "5000 or 6000 men under his orders:"

> This force appeared off Pensacola on the 9th of March, and Solano arrived soon after with the rest of his fleet, the whole amounting to fifteen vessels of the line, among which was the French squadron of M. de Monteil. Major-General Campbell, commander of the province, defended it with stubborn obstinacy, and sustained a siege of six weeks with great constancy and vigor. A shell which blew up one of the principal redoubts of the place at last forced him to capitulate, and on the 9th of May, 1781, Pensacola surrendered to the Spaniards, who became, in consequence, master of all West Florida.

Early in the siege, seven paroled officers were granted a permit by Campbell to leave Pensacola and proceed to the Spanish camp. They had been made prisoners in Gálvez's previous campaigns and came out to surrender to him "agreeable to their Promise given and Faith pledged." One of the seven was a Dr. Grant. Their families and slaves accompanied them, also three servants of the two ranking officers in the group.

Jackson at Pensacola

The second Spanish period in Florida was not terminated until 1821. Spain ceded the Floridas, East and West, to the United States on Feb. 22, 1819, but delayed ratification for two years. The Provisional Governor appointed to take possession in the name of the United States was one of the most distinguished personalities in American history, destined then to become the seventh President of the United States. Arriving on July 17, 1821 for the transfer of flags and sovereignty, Andrew Jackson, familiarly known to his troops and to posterity as "Old Hickory," entered Pensacola for the third time.

In the course of emerging as the dominant national figure of the teens and twenties of the nineteenth century, General Jackson briefly played an important role in Florida history. Born in Waxhaws Settlement, S. C. (now in North Carolina), on the Ides of March, 1767, a few days after his father's death, this intrepid leader found himself at the age of 15 an emaciated orphan of the Revolution, "tall and skinny as a split log," both "lonely and forlorn." He had enlisted at the age of 14 with the South Carolina forces, soon became a prisoner and was struck down by a sword in the hands of a British officer whose boots he refused to black. While in military prison he contracted

smallpox. His remarkable mother, Elizabeth Hutchison Jackson, obtained his release, through exchange, and nursed him back to health. Leaving him to nurse sick neighbors on a British hospital ship in Charleston, she succumbed there to yellow fever. Her other two sons gave their lives in the cause of the Revolution.

GENERAL ANDREW JACKSON (by Vanderlyn)
(Photo by R. A. Reilly)

From a painting in the Council Chamber, City Hall, Charleston, South Carolina.

Two years after being licensed to practice law at Salisbury, N. C., in 1786, Jackson went to Jonesboro and then on to Nashville, Tenn. In 1796 he was elected to the Congress as the first representative of that new state. From 1802 to 1814 he served as Major General of Tennessee Militia. During the War of 1812, a series of brilliant successes against the Creek Indians, allies of the British who had been guilty of many atrocities, led to their crushing defeat at Great Horse Shoe Bend on March 27, 1814. Two months later, he became a Major General in the United States Army with command of the Southern and Western divisions.

"On the prowl" after the Battle of Horse Shoe Bend, Jackson drove the British out of Pensacola on Nov. 7, 1814, where they had been inciting the Indians and had occupied fortifications with the consent of the Spanish. When Governor Maurique surrendered the town at discretion, Jackson refused to accept a surrender, saying that his object was merely to expel the British.

Jackson's stunning victory over the outnumbering experienced British troops at New Orleans on Jan. 8, 1815 made him the popular idol and hero of the American people during that era. On his birthday the following March, he expressed to members of his military family at New Orleans the wish that his mother — "gentle as a dove and brave as a lioness" — had lived to see that day. Declaring that her last words to her young son had been the law of his life, he shared them with his military companions:

> Andrew, if I should not see you again, I wish you to remember and treasure up some things I have already said to you. In this world you will have to make your own way. To do that, you must have friends. You can make friends by being honest, and you can help them by being steadfast. You must keep in mind that friends worth having will in the long run expect as much from you as they give to you. To forget an obligation or to be ungrateful for a kindness is a base crime — not merely a fault or a sin, but an actual crime. Men guilty of it sooner or later must suffer the penalty. In personal conduct be always polite but never obsequious. None will respect you more than you respect yourself. Avoid quarrels as long as you can without yielding to imposition. But sustain your manhood always. Never bring a suit in law for assault and battery or for defamation. The law affords no remedy for such outrages that can satisfy the feelings of a true man. Never wound the feelings of others. Never brook wanton outrage upon your own feelings. If ever you have to vindicate your feelings or defend your honor, do it calmly. If angry at first, wait until your wrath cools before you proceed.

In 1818, on his second visit to Pensacola his purpose was to cut off Spanish aid to the Indians whose uprisings and raids he had been sent to East Florida to quell. This time the

JAMES CRAINE BRONAUGH, M.D.

Photograph of a portrait in the Hermitage. Courtesy of the Ladies Hermitage Association, Hermitage, Tenn.

Spanish governor, Don Jose Masot, signed articles of capitulation which amounted to cession of West Florida to the United States.

General Jackson was therefore on familiar ground in July 1821 when he entered Pensacola for the third time. Again he did not tarry long, but as provisional governor he promptly set about the task of governing the state well. Soon after setting up a government, with George Walton of Georgia as governor, and dividing Florida into two counties, Escambia and St. Johns with the Suwannee River the dividing line, he returned to the Hermitage, his home in Tennessee near Nashville.

Jackson's Surgeon-Friend, Bronaugh

During his brief tenure of office, Jackson found that events did not move too smoothly. He was fortunate to have with him in Pensacola a surgeon who was a friend of long standing and a frequent visitor to the Hermitage.

Dr. James Craine Bronaugh, the son of William Bronaugh and his third wife, Rebecca Craine, was born in Loudoun County, Virginia on July 14, 1788. He was graduated from the University of Pennsylvania School of Medicine in 1809, the title of his graduation thesis being "Hepatitis." Little has been written concerning Dr. Bronaugh's life, and some of that is inaccurate. For instance, in his three volume "Life of Andrew Jackson" published in 1860, James Parton referred to Dr. Bronaugh as a "handsome young officer" who accompanied Andrew Jackson on a visit to East Tennessee in 1808. From records now available, that was a year before he was graduated in medicine and four years before he was appointed surgeon in the Army. He received the appointment of Surgeon of the Twelfth Infantry on April 28, 1812. In the same month two years later, he was appointed Hospital Surgeon, and again in April of 1818 he became Assistant Surgeon General. Parton described him in these words: "The General's military surgeon was a high-spirited Virginian, a stickler for the code of honor, heartily believing in the pistol as the great social regulator, and always prompt to act in accordance with that faith."

After Dr. Bronaugh's arrival in Pensacola with Andrew Jackson, Judge Brackenridge told this story of him:

> In the plenitude of his [Andrew Jackson's] power he permitted a fatal duel to be fought in Pensacola, in the most public and notorious manner, which a single word from him would have prevented it! I allude to the unfortunate affair of Hull and Randal, two young officers; the former just then reformed, and the other still in the army. Randal came from Baton Rouge on purpose, it was generally said, to draw a challenge from Hull, who had thrown out threats against him. The challenge was accordingly given by Hull; the duel took place; Dr. Bronaugh, the bosom friend of General Jackson, acting as physician. I was present when the doctor returned to communicate the result to the General, who was waiting impatiently to hear it. Poor Hull was shot through the heart; his pistol, which was a hair trigger, had stopped at half cock. The General was much displeased. "D—n the pistol," said he; "by G—d, to think that a brave man should risk his life on a hair trigger!" He was sufficiently generous not to arrest Randal, but gave him an intimation instantly to quit the town, which might have been given before the affair had taken place.

When Governor Jackson learned that President Monroe had appointed to subordinate offices in the new Florida government not a single man whom he had suggested, he was naturally chagrined. "Old Hickory" wrote to Dr. Bronaugh, whom he had recommended for the office of Receiver of Public Money: "I am determined never to be associated with such men. . . . Say to my friend Call [another whom Jackson had recommended for office] not to despond. . . . I am too sick to write more."

The Legislative Council of Florida was organized at Pensacola on July 22, 1821, at which time Governor Jackson administered the oath to its members. On motion to elect a president, the Council adjourned. On the following day after assembly, Dr. Bronaugh was called to the chair and was unanimously elected President of the Council. In his address to the Council, which immediately followed his election, Dr. Bronaugh said that he was conscious of possessing but little practical experience of the forms of legislation and he modestly expressed doubt that he would be able to come up to the just expectations of the members of the Council, but he called on them for guidance and support, stating:

> All I dare promise is rectitude of intention, strict impartiality, and a constant, zealous exertion, on my part, so to discharge the duties assigned me, as to merit your approbation.
> As the first legislative body assembled in this territory, we are called upon to perform a task of great importance to its future welfare — we are required to lay the foundations of the laws and government of a Territory, which, at present, although but little known, is perhaps destined, at no very distant day, to become one of the most wealthy and respectable members of the American confederacy. Let us, therefore, unite in the work with harmony and good will, and by the usefulness of our labors, satisfy the expectations of the people of Florida, and justify the confidence of the president and congress of the United States.

One of the first acts of Governor Jackson was the Ordinance for the Preservation of Health in the City of Pensacola, dated July 19, 1821, which is shown in the accompanying photograph.

ORDINANCE.

For the preservation of Health in the City of Pensacola.
By Major General Andrew Jackson, Governor of the Provinces of the Floridas, exercising the powers of the Captain General and of the Intendant of the Island of Cuba, over the said provinces, and of the Governors of said provinces respectively:

Sect. 1. That every vessel arriving between the first day of June and the last day of October, in each year, from any port between the Equator and thirty three degrees of north latitude, shall be brought to at the Barrancas, or at such other point as the Board of Health may direct, and there perform a quarantine of twenty-four hours at least, and as much longer as the Health Officer at Barrancas or such other point as the Board of Health may direct, and the Board of Health may deem necessary, not to exceed forty days.

Sect. 2. That there shall be established a Lazaretto at the Barrancas, or at such point as the Board of Health may direct, for the accommodation of the sick, under such regulations as the Board of Health may from time to time establish; and that until the Government of the United States shall establish a public warehouse at such Lazaretto, the cargoes, or such part thereof as the Health Officer and Collector of the port of Pensacola may deem necessary, shall be stored under the directions of the Commanding Officer of the Troops at Barrancas.

Sect. 3. That the Quarantine limits shall be cannon-shot-range or two miles in a direction towards the harbor from Fort St. Carlos de Barrancas, or at such point as the Board of Health may direct; and that any person or persons belonging to or having had communication with any vessel or vessels under Quarantine, who shall pass those limits without permission first had and obtained from the resident Physician or Health Officer, shall forfeit and pay a sum not exceeding three hundred dollars, and be imprisoned in the common jail for a term not exceeding six months.

Sect. 4. That for the more effectually guarding against the introduction of disease, there shall be established a Board of Health, which, for the present, shall consist of an Officer to be appointed and called the Resident Physician, and the Mayor and Aldermen of Pensacola, (over whom the Resident Physician shall preside) who are, by this Ordinance, authorised to make, and from time to time alter such laws and regulations as they may deem necessary, to ensure the health of the city.

Sect. 5. That there shall be a Health Officer appointed and stationed at the Barrancas, or at such other point as the Board of Health may direct, whose duty it shall be to board every vessel bound inwards, to see that the provisions of this Ordinance, and all such regulations as the Board of Health may make, are strictly complied with, and to report, from time to time, as occasion may require, to the Board of Health.

Sect. 6. That such allowances shall be made to the Resident Physician and Health Officer (all their services included) as shall not exceed one dollar and one half for each person on board of each vessel, to be regulated and determined by the Mayor of Pensacola, who is authorised to receive from every vessel, the cargo of which it may become necessary to land and store, such other and further sums as may be necessary to cover all expenses incident to the same.

Pensacola, July 19, 1821.

(Signed) ANDREW JACKSON.

By the Governor:

R. K. Call,

Acting Secretary of West Florida.

Para la conservacion de la salud en la ciudad de Panzacola.
Andres Jackson, Mayor General y Gobernador de las provincias de las Floridas, exerciendo en ellas la autoridad y poder que existian en el Capitan-General é Intendente de la Isla de Cuba sobre dichas provincias, y en los Gobernadores que eran de las mismas.

Secc. 1. Que cada Buque de los que arribarán en el plazo mediante del dia primero de Junio al dia último de Octubre de cada año, de qualquier puerto situado entre el Equator y treinta y tres grados de latitud al norte, será detenido á Barrancas (ú otro tal punto como lo determine la junta de salud) y hará allí una quarentena de veinte y quatro horas á lo ménos, y otro tanto tiempo como el Intendente de salud, en Barrancas (ú otro tal punto como la junta de salud lo determine) y la junta de salud crean necesario, como no exceda el término de quarenta dias.

Secc. 2. Que se establecerá en Barrancas (ó en otro tal punto como lo mande la junta de salud) un Lazareto para el alojamiento de las personas enfermas, baxo tales reglamentos como dicha junta de salud establezca de tiempo á otro; y que basta que el Gobierno de los Estados Unidos establezca un Almácen públicо para tal Lazareto, los cargamentos, ó tal parte de ellos como el Intendente de salud y el Colector del puerto de Panzacola crean necesaria, serán almacenados baxo la direccion del gefe comandante de las tropas en Barrancas.

Secc. 3. Que los límites de la Quarentena serán los de un tiro de canon, ó dos millas hácia el puerto desde el Fuerte de San Carlos de Barrancas (ó hasta tal punto como lo determine la junta de salud) y que á qualquier persona ó personas pertenecientes á qualquier buque ó buques en quarentena, ó que han tenido comunicacion con tales buques, que pasaren dichos límites, sin haberseles concedido permiso antecedente del médico residente ó Intendente de salud, les resultará la confiscacion y paga de una suma que no exceda trescientos pesos, y el ser encarcelados en la prision pública durante un término de seis meses á lo mas.

Secc. 4. Que con objeto de guardar mas eficazmente contra la introduccion de la enfermedad, se establecerá una junta de salud, la que sera compuesta, por lo presente, de un oficial que ha de nombrarse, y llamarse el Médico Residente, y del corregidor y regidores de Panzacola reunidos (quienes el Médico Residente presidirá) los que son, por este ordenamiento, autorizados de hacer, y de tiempo á otro mudar, tales leyes y reglamentos como á ellos les parezcan necesarios para asegurar la salud de la ciudad.

Secc. 5. Que se nombrará un Intendente de salud el que tomará su estacion en Barrancas (ú otro tal punto como por la junta de salud se mande) de cuya obligacion será abordar todos los buques dirigidos adentro, ver que se cumplan rigorosamente las disposiciones de esta ordenanza y todos quantos reglamentos haga la junta de salud, y comunicar de tiempo á otro, como lo exigiere la ocasion, con dicha junta.

Secc. 6. Que asi al Médico Residente, como al intendente de salud se les proporcionará á uno y otro tal remuneracion (todos sus servicios comprehendidos) como no exceda la suma de un peso y medio por cada persona abordo de cada buque, la qual se arreglará y determinará por el corregidor de Panzacola, quien está autorizado de recibir de cada buque, cuyo cargamento será necesario desembarcar y almacenar, tales otras y mas sumas como sean precisas para pagar todos los gastos, incidentes á lo mismo.

At a meeting of the Board of Health for the City of Pensacola on July 21, 1821, the following ordinance was read and adopted by the Board:

An Ordinance
Regulating the Practice of Medicine in the City of Pensacola

Resolved, That any physician who shall administer medicine in Pensacola or its dependancies, except in his own family, without a license from the Board of Health, shall for each and every offence pay the sum of twenty dollars.

Resolved, That any physician in Pensacola, who may wish to obtain a license to practice medicine, shall make application to the Board of Health for that purpose; and if two-thirds of the Board are satisfied that he is qualified, and that he is of correct moral character, he shall be licensed accordingly, on his paying to the secretary the sum of five dollars.

Every person practicing physic in the city of Pensacola, who shall have a patient sick of yellow, or billious, or pestilential or infectious fever, between the first day of June, and the last day of October, in every year, shall forthwith make a report in writing to the Board of Health, at their office; and for neglecting so to do, he shall forfeit for every offence three hundred dollars.

Two days later, at a meeting of the Board of Health, the president attended to a professional matter:

Dr. James C. Bronaugh, President of the Board, being desirous of applying for permission to practice medicine, George Bowie, Esq. was called to the chair — whereupon, James C. Bronaugh, M.D. presented his diploma, from the University of Pennsylvania, which was deemed sufficient, and was thereupon licensed to practice medicine in the city of Pensacola.

Doctor Bronaugh then resumed the chair.

John V. D. Voorhees, M.D. presented his diploma, from the University of New York, which was deemed sufficient, and was thereupon licensed to practice medicine in the city of Pensacola.

Doctor John Brosnahan, produced his credentials, which were deemed sufficient, and was thereupon licensed to practice medicine in the city of Pensacola.

The minutes of this meeting were signed by J. C. Bronaugh, Resident Physician and President of the Board of Health. The Board of Health was composed of the resident physician and the members of the City Council: George Bowie, Mayor; Wm. Barnett, John Keyser, George Fisher, Henry Michelett, John Innerarity, John Brosnahan, Aldermen. Dr. Voorhees was the Health Officer.

On Sept. 6, 1821, one of the last ordinances issued by Governor Jackson during his brief tenure of office conferred upon the Board of Health in Pensacola full power to regulate the practice of medicine and grant to physicians licenses to practice. It clarified and strengthened the original ordinance of July 21.

Dr. Bronaugh announced in September that Dr. Voorhees was associated with him in the practice of medicine and that at "their shop" next door to the Governor's office they would devote their time to professional business. Also during September, reports were circulated in New Orleans that yellow fever was prevalent in Pensacola. They were denied, and on September 8 an ordinance for "The Preservation of Health in the City of Pensacola" was published as follows:

Whereas it is of the first importance to the health and prosperity of the city of Pensacola, that no persons but such as are properly qualified, and licensed, should be permitted to practice medicine in the said city, (and such having been the law in these provinces under the late government of Spain) and in order to remove all doubts respecting the powers of the Board of Health, it is therefore

1. Ordained and declared that the Board of Health possess free power to regulate the practice of medicine in the city of Pensacola, and to establish rules and regulations for that purpose, and grant licenses to such persons as may be found qualified to practice.

2. It is further ordained, that Dr. Voorhees, Health Officer, and Doctors Elliott and Merrill of the United States Army be added to the Board of Health.

George Walton, Secretary of West Florida, announced soon after that:

The Board of Medical Censors will meet at the health office on Saturday the 15th inst. to examine all applicants for license to practice medicine and surgery. Those wishing to apply for license will leave their names with the secretary to the board of health the day previous to the examination.

The Terrible Enemy

The following year was destined to be fateful, and the hopes and plans of the little city came to a sudden end. When yellow fever was found to have invaded Pensacola, the following article appeared in the *Floridan* on Aug. 17, 1822:

. . . It is utterly inconceivable how any infection can rage here, as long as our bay continues salt, and the Gulph Stream breeze continues in its daily, luxurious office — our business for the present is with the plain matter of fact, the existence of yellow fever, within the limits of our town.

There have been several deaths within the last 7 days — say 7 or 8, a large and alarming proportion for the population — but we believe there are but 5 attributable to the terrible enemy.

All the cases have made their appearance, within the past week. The 1st was that of a gentleman, whose death is announced today, a seafaring man recently returned from the south. The 2nd was a young lady, but recently arrived from New Orleans. The 3rd was a lady, an ancient inhabitant. The 4th a youth of 16, exposed to sun. 5th a man with habits of excessive intemperance.

For the last 3 days there has been no new case — one remaining, a young and lovely lady, . . . There may be other cases, but if there are we know nothing of them.

. . . The doctors have recommended, and very wisely, all persons who are at all alarmed to leave town forthwith. . . .

Since writing the above we have heard of another case — a young woman who has been sick for 5 or 6 days. . . . We are confident that we have reported all the cases. . . . No new cases. . . .

It is a remarkable fact . . . that there have been no cases among the poorer class of people . . and others most exposed . . . moreover the Battalion of the 4th Infantry, quartered in town, are at this moment more healthy than they have been at any period for several years back — thruout the corps no fever.

When yellow fever appeared, the Council left the City and held its sessions at Fifteen Mile House, now Gonzalez, Fla., but the members did not escape. Dr. Bronaugh was one of the first victims. It was believed that from August 15 to September 11 not less than 120 persons died in Pensacola of the "pestilence," a mortality without precedent up to that time. Among the names of the deceased were the following prominent people:

> Dr. Bronaugh, president of the legislative council; Major Underwood; Judge Shannon; J. Connor, secretary to the governor; Mr. Car, commedian; Captain Crocker, of the sloop Intrepid; Mr. Bradford, sheriff; Mr. Kennedy, deputy; Mr. Harrison of Washington city, and his family; F. Johnson, Mrs. Johnson, and two Misses Johnson, J. Keyser, New York; Mr. Kennedy, merchant; Judge Foster, Mr. and Mrs. Stutson, J. H. Champlin, esq., Dr. Rogers of Baton Rouge; Dr. Elliott, U.S. Army; Captain Young, U.S. Engineers; Mr. Wadlington, clerk to the paymaster; Miss Benson, Miss Ker, Mrs. Dinkins, Mr. Saltonstall, Mr. Newton, wife and child, Captain Gerrish, Mr. Simms, navy agent, and W. H. Flournoy, esq.

When Andrew Jackson, who had returned to Nashville, heard of Dr. Bronaugh's death, he wrote:

> Being absent, I did not receive your letters until the 26th inst. rehearsing the dreadful calamity that has befallen Pensacola and our friends. You can more easily judge of my feelings than I can express them when I received the intelligence of the death of my friend, Dr. Bronaugh. . . . My mind is too much overshadowed with sorrow and gloom to write. This visitation will materially affect the growth of Pensacola — its promised health was the basis of its future greatness, and nothing but time and a strict vigilant police can regain its character for health. How I regret the untimely death of my friend Bronaugh. Could I have been with him to have afforded him that kind attention so often bestowed on me, I would be more content. . . .

The Editors thank Mr. Julien C. Yonge, Editor of the Florida Historical Quarterly and Director of the P. K. Yonge Library of Florida History at the University of Florida, and Miss Audrey Broward, Research Librarian of the Jacksonville Public Library, for their generous help and advice in the preparation of this article.

They also thank The Ladies Hermitage Association, Hermitage, Tenn., for obtaining the photograph of the portrait of Dr. Bronaugh which hangs in the Hermitage near Nashville, Tenn., and Miss Frances R. Houston, Executive Secretary of the Medical Society of the University of Pennsylvania for furnishing from the records of that institution data on Dr. Bronaugh heretofore unpuhlished.

NOTICE

Your March Journal carried a complete program and other detailed information relative to the Seventy-Ninth Annual Meeting of the Association in Hollywood, April 26-29.

The Doctor Looks Ahead

The first woman physician ever to serve as president of the county medical society in Westchester County, New York, gave her fellow physicians a timely bit of advice when she retired from that office recently. "Now that we have a change in government and policies," observed Dr. Margaret Loder of Rye, N. Y., "it is not at all impossible that many of us may sit back and feel that there is no need for continuing to protect our freedom, and at the same time to give to our people the very best that they can have at a cost which each one will be able to pay.

"Perhaps many of us will feel that we can relax, and sit back and take it easy. That is not so. We are never going back to the 'good old days.' The Cadillac and airplane have replaced the horse and buggy, and the thinking and demands of our people have not remained behind but have kept pace with the more recent methods of transportation. We have no right to be complacent. The medical profession must not wait for others to do their job, they must lead the way."

This sentiment merits the hearty approval of medical societies across the nation as well as the commendation it received from the lay press. Just because the pressure has lessened somewhat, at least temporarily, now is no time for the medical profession to relax. No longer on the defensive, it must take care to keep the initiative.

Straws in the Wind

Is socialized medicine dead? Perennially, Representative Dingell (D., Mich.) can be counted on to keep the issue alive. Nothing daunted by the change of administration in Washington, he introduced compulsory national health insurance legislation as soon as the new Congress opened for business. "It is my aim," he declared, "to keep this legislation before Congress." At the same time he stated that his bill had the same objectives as the report of the Truman Commission for the Health Needs of the Nation and the "same freedom from socialistic taint."

Likewise, C.I.O. President Walter P. Reuther has given full support to the program of the Truman Commission. Speaking early in February at the Philip Murray Awards dinner in New York, where Oscar Ewing received one of the awards for promoting social welfare legislation, he demanded that the present administration redeem campaign

promises through promotion by the federal government of "a comprehensive health program for all the American people," based on the Commission's findings. He would have the federal government enlist the aid of states and private practitioners and institutions to provide comprehensive medical care, remedial and preventive, for those who could not afford it. He also declared that C.I.O. unions would seek improved health and social security provisions in all future contract negotiations.

This same report of the Truman Commission was scheduled to be the big feature of the annual meeting of the National Health Council in March. This forum offers "an ideal springboard for tooting, publicly, the commission's recommendations, which would lead to compulsory health insurance for a large segment of the American people." The council invited 500 key health people from all over the United States to attend. Its membership includes the nation's major professional societies and voluntary organizations in the health field, plus governmental and business groups that are advisory and sustaining members.

One member organization, the American Medical Association, strongly urged postponement of the March meeting or adoption of a different topic for discussion. This action was taken on the ground that in such an important and controversial matter, complete information should be available for detailed study before public discussion. Of the five volume report, only the volume containing conclusions and recommendations, but not the basis for such decisions, was available in time for study. The protest, however, was of no avail. Council president, Mrs. Oswald B. Lord, is quoted in a council press release as saying that "the National Health Council has a duty to tell the American people what it thinks of the commission's report."

Among straws blowing in the opposite direction is the vigorous attack made recently on socialized medicine by Dr. Milton S. Eisenhower, brother of and now adviser to the President. At a dinner of the American Heart Association in New York, he avowed his "passionate" belief in private enterprise and told his audience that "the socialization of medicine would be a fatal step that would lead to the loss of economic freedom, and, therefore, to the loss of political and personal freedom, too."

There is also the statement of House Majority Leader Halleck, quoted in a recent Associated Press story, in which he said that the House was "not going to get into the field of compulsory government insurance." The same source quoted Representative Judd (R., Minn.) as saying that the whole Federal Security Agency needs a housecleaning and persons placed in charge who will cooperate with the American Medical Association on a program for better distribution of a higher grade of medical care. In his opinion, cooperative Federal Security officials would find the medical profession "happier to go along" on health programs "than any other group in the nation." Slapping at "crusaders" in the Federal Security Agency, Dr. Judd was "sure that Mrs. Hobby will put in people interested in solving the problem rather than promoting a particular panacea."

From press reports, it appears that Mrs. Oveta Culp Hobby of Texas, wartime WAC commandant, is off to a good start as the new Federal Security Administrator. Certainly the least the physicians of the country can do is to wish her well and support her at the grass roots level as occasion arises so long as she upholds the principles of free medicine in a country built on freedom.

The Bricker Resolution

The now familiar "Bricker resolution" (S. J. RES. 1), which would forbid United States participation in any international treaty or executive agreement superseding the laws of this country, is of vital importance to the medical profession. Its progress in the Congress and final disposition concern every physician and the future of medical practice as well as the general welfare of the land.

The resolution is sponsored by Senator Bricker (R., O.) and 63 other Senators, who will press for early action on it. In his testimony before a subcommittee of the Senate Judiciary Committee, Senator Bricker singled out the International Labor Organization as among the United Nations agencies working on treaties affecting American citizens. The Senator commented that ILO's "modest ambition is to become the economic overseer of all humanity."

An editorial entitled "ILO — Danger Ahead!" in the October 1952 issue of The Journal pointed out that this nation is now under greater threat of socialism by treaty than by domestic legislation and urged widest recognition of the possibility of

political and economic regimentation from external sources. It cited a treaty adopted last June by the ILO, embodying socialized medicine, which requires only a two-thirds vote of the Senate for ratification, making it the law of the land regardless of the will of the people.

On Feb. 18, 1953, Dr. George F. Lull, Secretary and General Manager of the American Medical Association, submitted to the subcommittee the views of that organization on S. J. RES. 1 and similar measures pending before the Committee. The statement declared in part: "The American Medical Association is heartily in accord with the purposes of these proposals. The Board of Trustees and the House of Delegates of the Association on two occasions have emphatically endorsed the principle that the scope of treaties and executive agreements should be limited. It is the belief of the Association that such a limitation is necessary to avoid any abridgement of the rights enumerated in the Constitution and to prevent the adjudication of domestic issues by such measures."

The American Medical Association declared itself in favor of "the measure which would most effectively provide for such an amendment to the Constitution." The American Bar Association is among other organizations supporting the resolution.

Action now appears to be in sight on this bill which would make humanitarian treaties subject to two conditions: (1) no such treaty could be effective if it would undermine constitutional rights of American citizens, and (2) no such treaty would be effective if it would entrust the rights of American citizens to supervision of international agencies over which they exercise no control. Physicians across the nation will watch with peculiar interest and appropriate concern the progress of this measure which would block the new international approach to socialism in this country.

American Medical Education Foundation Plans for 1953 Campaign

At a meeting in Chicago late in January, state chairmen and other representatives of the American Medical Education Foundation from 45 states formulated plans for the 1953 campaign to raise funds within the medical profession to aid the nation's 79 medical schools. Dr. Jack Q. Cleveland of Coral Gables, chairman of the Association's Committee on Medical Education and Hospitals, represented Florida at the meeting.

The first recipient of the foundation's Award of Merit was Dr. Louis D. McGuire, Omaha physician and chairman of the Nebraska A.M.E.F. Dr. McGuire received the award for his outstanding contributions to the preservation and continuing high standards of medical education in the United States.

Dr. McGuire reminded the group that the threat of federal aid to medical education is not a dead issue. "We all know," said he, "how that great American, President Eisenhower, feels. He believes that state and private sources should accept the responsibility for supplying the additional funds needed by the medical schools. But we do not know what will happen in 1956. American medicine must make good in many ways in the next four years. This is not the time for apathy and complacency . . . federal subsidy of the medical schools will be forthcoming if the doctors and business men fail."

The foundation set a goal of $2,000,000 during 1953 as its contribution toward the $10,000,000 needed to augment the national fund for the medical schools. Industry and other sources outside the medical profession are expected to contribute the remainder of the funds needed. During 1952, the foundation received over $900,000 from 7,250 contributors, including a grant of $500,000 from the American Medical Association.

Re-elected recently for a third term, Dr. Elmer L. Henderson of Louisville continues as president of the foundation. Succeeding Dr. Harvey B. Stone of Baltimore, A.M.A. President Louis H. Bauer of Hempstead, N. Y., is now vice president of this important organization.

Articles Concerning Stress and the Adaptive Hormones

The Institute of Experimental Medicine and Surgery of the University of Montreal initiated in 1950 the publication of a series of reference volumes entitled "Annual Reports on Stress" (Acta Medical Publishers, Montreal) in which the entire current world literature is surveyed every year. This undertaking by Dr. Hans Selye, Director of the Institute, and Dr. Alexander Horava, coauthor, is a formidable task in view of the 2,000 to 4,000 pertinent articles now added annually to the medical literature. Since the success of research in this complex and rapidly developing field largely depends upon the prompt availability and evaluation of relevant publications, the authors

urge investigators interested in research on stress and the so-called adaptive hormones (ACTH, STH, corticoids, adrenergic substances, et cetera) to send them their reprints for this purpose as soon as they become available. This cooperation of authors of original papers with the reviewers will greatly facilitate the rapid inclusion of current papers in these annual reports.

The first of the annual supplements to Dr. Selye's book entitled "Stress — The Physiology and Pathology of Exposure to Stress" was reviewed in the July 1952 Journal, and the current one is reviewed in this Journal. Also, a review of "The Story of the Adaptation Syndrome," which is a series of informal lectures on the stress problem by Dr. Selye, was published in the January 1953 Journal.

Graduate Medical Education

Twenty-First Annual Graduate Short Course June 22-27

June 22 to 27 inclusive are the dates this year for the Graduate Short Course. As in previous years, this twenty-first annual graduate course for doctors of medicine will be held under the auspices of the Department of Medicine of the Graduate School of the University of Florida, the Florida State Board of Health and the Florida Medical Association. The meetings will be held at the George Washington Hotel in Jacksonville.

A strong faculty is assured, and the program has been planned with the interests of the general practitioner particularly in mind. The faculty members and their subjects were announced in The Journal last month. The complete program with schedule of classes will be published in the May Journal.

Seminar on Gastroenterology June 18-20

Following the established custom of recent years, a three day Seminar will be held immediately preceding the Short Course. Gastroenterology will be the subject this year. Dr. H. Marvin Pollard, Associate Professor of Internal Medicine at the University of Michigan, will deliver the lectures. The Seminar will begin at 9 a.m. on Thursday, June 18, and continue until Saturday noon, June 20. There will be a general review with question and answer period on Saturday morning. Advance registration will help the committee in making arrangements for this graduate training which affords an exceptional opportunity and should be of particular interest to many Florida physicians.

Florida Clinical Diabetes Association May 14-15

The first annual meeting of the Florida Clinical Diabetes Association will be held on May 14 and 15 at the Suwannee Hotel in St. Petersburg. As announced in detail in the March Journal, the guest speakers will be Dr. Howard Root of the Joslin Clinic, Boston, and Dr. F. B. Peck, Director of the Medical Division of the Lilly Research Laboratories in Indianapolis, both of whom are well known in Florida.

In addition to twelve lectures by these distinguished medical teachers who have contributed much to the study of diabetes mellitus, there will be papers by members of the association. On Friday evening, Dr. Root and Dr. Peck will address a meeting to which the public will be invited.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Aaron Z. Oberdorfer of Jacksonville announce the birth of a daughter, Caron Lee, on Jan. 17, 1953.

Dr. and Mrs. Ben T. Franklin, Sr., of Jacksonville announce the birth of a son, David Frederick, on Feb. 9, 1953.

Dr. and Mrs. Henry B. Dickens, Jr., of Fernandina announce the birth of a son on Feb. 10, 1953.

Deaths — Members

Dawkins, N. J., Vernon	Nov. 9, 1952
Miles, Walter G., Chattahoochee	Nov. 16, 1952
Paulk, George A., Miami	Feb. 9, 1953
Moore, Thomas J., St. Petersburg	Feb. 21, 1953
Wilkins, Walter E., Jacksonville	March 2, 1953

Deaths — Other Doctors

Bartee, L. H., Port St. Joe	Feb. 16, 1953
Kerr, James E., Winston-Salem, N. C.	Feb. 18, 1953

NOTICE

Your March Journal carried a complete program and other detailed information relative to the Seventy-Ninth Annual Meeting of the Association in Hollywood, April 26-29.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Abberger, Benjamin L., Jr., Orlando
Augustus, Charles A., (Col.), Pensacola
Bailey, Taylor D., Kissimmee
Bradford, Edward, Winter Garden
Bradley, James L., Fort Myers
Byrne, Edward G., Pensacola
Campbell, James L., Jr., Orlando
Cleveland, Robert H., Jacksonville
Collins, Thomas R., Orlando
Coy, Francis M., Orlando
Crage, Francis M., Sarasota
Duest, Lloyd J., Sarasota
Felos, Pete G., Starke
Ferran, Harry H., Orlando
Fitz, Thomas E., Lakeland
Hartsfield, Richard C., Orlando
Healy, Raymond W., Crystal River
Johnson, Edwin A., Clewiston
Kenet, David S., Lakeland
Lay, Coy L., Lakeland
Macdonald, Ian J., Orlando
Meli, John J., Naples
Morrow, Joseph R., Coral Gables
Murphy, George M., Orlando
Murray, Charles A., Orlando
Oleson, Dunlap W., Sarasota
Peres, Charles E., Jr., Fort Myers
Romoser, William C., Sarasota
Shain, Joseph H., Homestead
Shupe, Henry W., Clewiston
Startzman, John E., Orlando
Stewart, Thomas J., Century
Stone, S. Montague, Miami Beach
Trygstad, Ethel H., Naples
Wigderson, Charles B., Miami Beach
Zaugg, Frederick B., Coral Gables

STATE NEWS ITEMS

Dr. Donald M. Baldwin of Jacksonville was guest speaker to members of District 2, Florida State Nurses Association in February.

Dr. Charles A. Murray of Orlando announces the opening of his office at 1219 North Orange Ave. for the practice of urology.

Dr. Joseph D. Foley of Jacksonville gave a talk on behalf of the Heart Drive at a recent luncheon meeting of the Woman's Club of Jacksonville.

An abstract of Dr. Morris Waisman's article, "The Dermatologic Dangers of Sunlight," which appeared in the October Journal, has been published in the January issue of the "American Perfumer and Essential Oil Review." Dr. Waisman's paper was read at the Association's Annual Meeting in Hollywood last April.

Dr. James A. Winslow, Jr., of Warrington entered the U. S. Navy with the rank of lieutenant on Nov. 1, 1952.

Dr. Walter C. Payne of Pensacola served as chairman of the "legislative preview" of public health problems held February 13 at the San Carlos Hotel. The preview, one of six held throughout the state, was sponsored by the Florida Public Health Association.

Dr. Rex M. Bleakney of Orlando was guest speaker at the February meeting of the Orlando Police Officers' Auxiliary. He also showed a film on self-examination for detection of cancer.

Dr. Wilbur C. Sumner of Jacksonville, director of the Tumor Clinic of the Duval County Medical Center, discussed phases of cancer and conducted a question and answer period recently at the Jacksonville Beach Theatre. The talk followed the showing of a film on self-examination, sponsored by the Jacksonville Beach Woman's Club.

Dr. Howard A. Engle of Miami Beach appeared on the Cerebral Palsy TV program in January.

Dr. Robert V. Edwards of South Miami spoke on "High Blood Pressure" at a recent luncheon meeting of the Allapattah Exchange Club.

Dr. William P. Hixon of Pensacola spoke on heart diseases at February meetings of the Pensacola Optimist Club and the West Pensacola Civitans.

Dr. James L. Anderson of Miami spoke at a recent meeting of the Dade County Medical Association's Woman's Auxiliary.

Dr. Edward M. Langer of Sarasota spoke at the February meeting of District 20 of the Florida Nurses Association. His subject was "Hypertension."

Drs. W. Tracy Haverfield of Miami, William H. McCullagh of Jacksonville, Luther C. Fisher, Jr., of Pensacola, and William H. Grace of Fort Myers are among 17 men and women appointed by Governor Dan T. McCarty on a citizens committee to study Florida's mental health problems and recommend improvements in the state's facilities and methods of treating the mentally ill.

Dr. J. Champneys Taylor of Jacksonville gave a paper on "Pencillin Therapy in Pre-eclamptic Toxemia," at the meeting of the South Atlantic Association of Obstetricians and Gynecologists in Havana in January.

Dr. Theodore M. Berman of Miami Beach is the new president of the Greater Miami Radiological Society. Other officers are Drs. David Kirsh, Miami, vice president, and E. Hampton Bryson, Coral Gables, secretary-treasurer.

Dr. Walker Stamps of Jacksonville has been elected assistant treasurer of the Duval County Welfare Board for the ensuing year.

Dr. Peritz Scheinberg of Miami was elected vice president of the Southern Society for Clinical Research at New Orleans in January.

Dr. Frank G. Slaughter of Jacksonville spoke at the Jacksonville Junior College in January. He reviewed his latest novel, "The Galileans."

Dr. William Wickman of Miami has been certified by The American Board of Surgery.

Dr. Frederick H. Bowen of Jacksonville spoke on cancer at the February meeting of the Dads' Club Federation.

Dr. Grace C. Hardy of Jacksonville spoke on "Making Tomorrow's History" before the Arlington Junior Woman's Club in February.

Members appearing on the Dade County Medical Association "Tell Me, Doctor" radio program recently were Drs. A. Wm. Wallace and William S. Piper, Coral Gables; Efton J. Thomas, Miami Beach; William K. Boros, Theodore R. Struhl, Louis Lemberg, James H. Putman, Jack L. Wright, Bernard D. Ross, Morton M. Halpern, and DeWitt C. Daughtry, Miami; Robert A. Mayer, Miami Shores; Valentine Bloch, North Miami; and Robert V. Edwards, South Miami.

The Florida Chapter of the American Academy of Pediatrics was organized in April, 1952 at Hollywood. Dr. Hugh A. Carithers of Jacksonville was elected president and Dr. Wesley S. Nock of Coral Gables, secretary-treasurer.

This Academy Chapter is separate and distinct from the Florida Pediatric Society. The Board of Governors of the F.M.A. has approved the Florida Pediatric Society as a specialty group that may hold meetings the day prior to the annual meeting of the Florida Medical Association. The Florida Chapter of the American Academy of Pediatrics does not plan to have scientific meetings but will meet with the national representatives on special occasions.

Dr. Paul F. Hutchins of Jacksonville has returned to his practice after a year's graduate work in Basic Sciences and Adult Rehabilitation at the Ochsner Clinic.

Dr. Hunter B. Rogers of Miami spoke on "How To Keep Healthy After 45," on the "Golden Years" program over radio station WIOD recently.

Dr. Sullivan G. Bedell of Jacksonville was the subject of a "thumbnail sketch" in the January Newsletter of the Northeast Florida Association for Mental Health.

Dr. Ben J. Sheppard of Coral Gables and Dr. Milton S. Saslaw of Miami took part in panel discussions on the "Hope Unlimited" program over radio station WQAM.

Dr. Wilson T. Sowder of Jacksonville headed a panel on health problems of Florida children at an open forum held in Jacksonville in January under the auspices of the Florida Children's Commission.

Dr. Wilbur C. Sumner of Jacksonville was chairman of Religion and Life Week held in February at the Riverside Baptist Church.

Dr. James T. Hardy of West Palm Beach entered the U. S. Air Force in March with the rank of Major.

Dr. Ralph W. Jack of Miami spoke on "Relationship of Any Medical School to the Community, Professional and Public," before the Coco Plum Woman's Club in South Miami recently.

Drs. Richard C. Clay, Joseph W. Scott, L. Washington Dowlen and Frank M. Woods of Miami appeared on the regular WIOD American Cancer Society's programs recently.

Dr. Homer L. Pearson, Jr., of Miami spoke on "Religion and Medicine" before an adult Sunday School Class at the Allapattah Methodist Church in February.

Dr. Bernard D. Ross of Miami spoke on "Climate and your Health" at on open meeting of the Miami Shores Business and Professional Woman's Club recently.

Dr. James L. Anderson of Miami appeared with the showing of the Mental Society's Film, "Breakdown," dealing with schizophrenia before a large group in the auditorium of the Board of Public Instruction recently.

Dr. Turner Z. Cason of Jacksonville was the speaker in the second of a series of Lenten services at the Church of the Good Shepherd. General theme of the series is "Religion and Health."

Drs. H. Clinton Davis and E. Sterling Nichol of Miami and David A. Nathan of Miami Beach appeared on the Judy Wallace "Woman's World" TV program during February to discuss heart disease.

Dr. Sidney Davidson of Lake Worth spoke on the need of funds for the study of heart disease at a recent meeting of the Boynton Beach Rotary Club.

Dr. Ira C. Evans of St. Petersburg has accepted the post of Pinellas County Medical Examiner. Drs. James O. Norton of Dunedin and Paul F. Wallace of St. Petersburg will serve as assistants.

Dr. James N. Patterson of Tampa attended his first official meeting of the American Board of Pathology since he was elected a trustee member of the Board in October. The meeting was held in Chicago and was a pre-examination meeting to pick out the questions to be asked in pathologic anatomy and the various subjects in clinical pathology for the certification examinations given in St. Louis in March and to be given in Chicago in April. Dr. Patterson is giving the examination in clinical microscopy.

En route to Chicago, Dr. Patterson attended the South Central Regional meeting of the College of American Pathologists in New Orleans.

Dr. William M. C. Wilhoit of Pensacola spoke on mental health needs for Escambia County at a meeting of the Escambia Youth Service League recently.

Dr. H. Phillip Hampton of Tampa was questioned about the proposed Hillsborough County Hospital Authority on the first broadcast of the Jaycee Press Conference on WFLA on February 27. Dr. Hampton also explained the proposed bill at a meeting of the Tampa League of Women Voters at a general meeting held recently.

Dr. J. Maxwell Williams, Jr., of Tampa has returned to his practice after attending Johns Hopkins Society meetings in Baltimore in February. He remained in Baltimore after the meetings for study at the Heart Station.

Dr. Thomas H. Bates of Lake City spoke on the place of the physician of today in the life of Florida as well as America as a whole at a recent luncheon meeting of the Lake City Rotary Club at the Blanche Hotel in Lake City.

Dr. James R. Nieder of Delray Beach spoke on "Cataract Extraction" at a meeting of District 9, Florida State Nurses Association recently.

Dr. Edward L. Cole, Jr., of St. Petersburg entered military service on Jan. 8, 1953, with the rank of lieutenant (USNR).

Drs. Benjamin F. Streets of Pinellas Park and Irvin S. Leinback and Roderic L. Boling of St. Petersburg were recently presented awards by the Pinellas County Society for Crippled Children and Adults in appreciation of work and time given to the organization.

Dr. Thomas H. Lipscomb of Jacksonville is heading the 1953 Easter Seal sale drive in Duval County. The drive is held annually by the Society for Crippled Children and Adults.

Dr. Frank C. Bone of Orlando entered military service on Nov. 17, 1952, with the rank of lieutenant (USNR).

Dr. Frank G. Slaughter of Jacksonville will be the banquet speaker for the fourth semi- annual meeting of the Florida Newspaperwomen's Club to be held in Jacksonville April 18-19.

Dr. Leroy H. Oetjen of Leesburg has returned to his practice after attending a course in the Medical Aspects of Atomic Energy at the Naval Medical Hospital in Bethesda, Md.

Dr. Samuel M. Day of Jacksonville was guest speaker at a meeting of the Assumption Parish Guild recently.

President Robert B. McIver of Jacksonville has announced the fraternal delegates from the Florida Medical Association to the annual meeting of the Medical Association of Georgia in Savannah, May 10-13 are Drs. Chas. J. Collins, Orlando; Jackson L. Allgood, Jr., Jacksonville; and Merritt R. Clements, Tallahassee.

Dr. Bernard L. N. Morgan of Jacksonville announces the opening of his offices at 241 West Ashley St. for the practice of plastic surgery.

For the first time, the Florida Orthopedic Society and the Dade County Pediatric Society are holding a joint meeting in Miami. Sponsored together with the Nemours Foundation, these groups will present speakers of national reputation in the fields of Orthopedics, Pediatrics and Poliomyelitis. A very fine program has been prepared. All doctors of medicine who are interested in attending are urged to register in advance. For information, write Gunnard J. Antell, M.D., 273 Alhambra Circle, Coral Gables.

The annual conclave of The American College of Allergists will be held this year at the Conrad Hilton Hotel in Chicago, April 24-29. For detailed information, write The American College of Allergists, La Salle Medical Building, Minneapolis 2, Minn.

Seventy-Ninth Annual Convention
Florida Medical Association
Hollywood, April 26-29, 1953

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

FOR RENT: Lincoln Road office, Miami Beach. Waiting room furnished. Reasonable. Write 69-79, P. O. Box 1018, Jacksonville, Fla.

WANTED: Internist or General Practitioner for furnished office in northeast section of Miami. Write 69-80, P. O. Box 1018, Jacksonville, Fla.

GENERAL SURGEON: 33; Board eligible. Five years training teaching hospitals. Experienced general, gynecologic, traumatic, urologic surgery. Desires associateship or group practice. Florida license. Available immediately. Write 69-81, P. O. Box 1018, Jacksonville, Fla.

GENERAL PRACTITIONER: Desires Florida location. Will also consider institutional, industrial or aviation association. Good Geriatrics experience. Have Florida license. 43 years old. Write 69-85, P. O. Box 1018, Jacksonville, Fla.

PEDIATRICIAN: 39, Board eligible, desires location, association or group. Miami. Married, family, willing to invest. Best references. Write 69-87, P. O. Box 1018, Jacksonville, Fla.

LOCATION WANTED: To practice surgery; Central or West Florida preferable; Best references; 10 years experience. Available immediately. Write 69-88, P. O. Box 1018, Jacksonville, Fla.

FOR SALE: Long established beach city office, 5 beautifully furnished, completely equipped. Hamilton furniture, machines, apparatus. Ready for immediate practice. Excellent opportunity for beginner. Price reasonable, easy terms. Write 69-89, P. O. Box 1018, Jacksonville, Fla.

WANTED: Pediatrician, board or board eligible, Florida license, for association with two internists. $7,200 to start. Please write particulars at once to P. O. Box 809, Lake Worth, Fla.

EXCEPTIONAL OPPORTUNITY: For active capable General Practitioner; Fully equipped office, Established practice; With or without investment; Entering military service; Contact immediately 276 N.E. 27th Street, Miami.

PRACTICE FOR SALE: Practice, equipment and office available on Gulf Beaches for G.P. near St. Petersburg. Wonderful opportunity and possibilities. Contact: Mrs. T. J. Moore, 15601 Redington Dr., St. Petersburg. Phone 9-3352.

The President will deliver his annual address at the first meeting of the House of Delegates, Tuesday morning, April 28.

COMPONENT SOCIETY NOTES

Bay

At the February meeting of the Bay County Medical Society, Dr. William M. C. Wilhoit of Pensacola spoke on "Neurology from the Standpoint of the General Practitioner." He presented case histories of drug intoxication, spinal cord tumor, convulsive disorders, and Parkinsonism.

Dade

At the March meeting of the Dade County Medical Association, Drs. Benjamin G. Oren and Donald F. Marion, both of Miami, spoke on "Diagnosis and Treatment of Diarrheal States."

Duval

The regular March meeting of the Duval County Medical Society was held at the U. S. Naval Hospital Auditorium. Speakers were Lt. R. N. Webster who spoke on "Traumatic Injuries to the Urinary Tract," and Lt. Frank C. Bone who spoke on "Practical Aspects of Salt and Water Metabolism."

Franklin-Gulf

The Franklin-Gulf County Medical Society has paid 100 per cent of state dues for 1953.

Guest speaker at the February meeting of the Society was Dr. Francis T. Holland of Tallahassee who spoke on "Cancer in the Young."

Lee-Charlotte-Collier-Hendry

One hundred per cent of state dues for 1953 have been paid by the Lee-Charlotte-Collier-Hendry County Medical Society.

Marion

Dr. Joseph A. J. Farrington of Jacksonville spoke on "Penicillin and Other Antibiotic Reactions," at the regular February meeting of the Marion County Medical Society. The talk was followed by a question and answer round-table discussion.

Monroe

Dr. Edward W. Shannon, Cleveland neurological surgeon, addressed the February meeting of the Monroe County Medical Society. Dr. Shannon spoke on "The Diagnoses and Treatment of Traumatic Injury of the Brain."

Palm Beach

Dr. George G. Ornstein of New York, a national authority on chest diseases, spoke at the February meeting of the Palm Beach County Medical Society. Dr. Ornstein is FACP director of the Seaview Hospital, New York City, and is a professor of medicine at the New York Polyclinic Hospital Medical School and at New York Medical College and Flower Hospitals. He spoke on the latest treatment of tuberculosis and other lung diseases.

Pinellas

The guest speaker at the regular meeting of the Pinellas County Medical Society on March 6 was Dr. M. A. Blankenhorn, Director of the Department of Internal Medicine, Cincinnati General Hospital, who spoke on "Acute Intoxication and Infections of the Myocardium." The speaker was a guest of the V. A. Hospital staff.

Seminole

The Seminole County Medical Society has paid 100 per cent of its state dues for 1953.

Volusia

Dr. Robert L. Miller of Daytona Beach, who for twenty years has been secretary of the Volusia County Medical Society, was honored by the Society on February 10 with a surprise dinner. Dr. Miller, who has also served as president of the Society, was given a set of power tools in commemoration of his long years of service to the Society and to the community.

Dr. Morris B. Seltzer, Society president, was master of ceremonies at the dinner, and speakers included Drs. Joseph A. Rutter, George M. Green and Herbert A. King of Daytona Beach, and Hugh West of DeLand.

Walton-Okaloosa

One hundred per cent of state dues have been paid by the Walton-Okaloosa County Medical Society.

S. A. Kyle *Funeral Director*

MEMBER National Selected Morticians BY INVITATION

17 WEST UNION STREET
JACKSONVILLE 2, FLORIDA
Phones 5-3766 5-3767

Washington-Holmes

The Washington-Holmes County Medical Society has paid 100 per cent of its state dues for 1953.

Robert L. Miller, M.D., Secretary, Volusia County Medical Society

BOOKS RECEIVED

Second Annual Report on Stress. By Hans Selye, M.D., Ph.D., D.Sc., F.R.S., and Alexander Horava, M.D. Pp. 526. Price, $10.00. Montreal, Canada, Acta, Inc, Medical Publishers, 1952.

This volume represents the second of a series of annual supplements to the book "Stress — The Physiology and Pathology of Exposure to Stress" by the senior author. These publications serve as guides to the entire literature on stress and as aids in correlating the pertinent facts, many of which may appear to be quite unrelated. Within the brief span of the last 16 years, during which the stress concept has taken place, and particularly during the last three years since ACTH and gluco-corticoids have become generally available, most physicians have sought to familiarize themselves with some facet of this comparatively new subject which has already affected almost every aspect of medicine. In these fields of biologic stress, the General Adaptation Syndrome (G-A-S), and of the so-called "adaptive hormones," critical evaluation of newly acquired data and their prompt integration into the body of classic knowledge are, therefore, highly important.

Interest continues to mount, since this second report refers to over 4,000 publications, 1,000 more than last year's report. These reports are written as a combination of an extensive classified index of pertinent new facts with a concise evaluation of the principal findings.

Inhibition of Excess Parasympathetic Stimuli in Peptic Ulcer with Banthine®

Medical literature now contains more than 200 references to the beneficial role of Banthine Bromide (brand of methantheline bromide) as evidenced by a marked healing response of peptic ulcers. Rapid symptomatic improvement, particularly with reference to pain relief, is followed by roentgenographic demonstration of crater filling.

The therapeutic action of the drug in decreasing hypermotility and hyperacidity, together with the remarkable early subjective benefit, is indeed a desired approach in ulcer management.

Treatment is individualized to the patient's needs. One or two tablets (50 to 100 mg.) is administered every six hours, around the clock, in conjunction with appropriate diet control and antacid medication as indicated.

Banthine is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. Searle: Research in the Service of Medicine.

Ulcer Facies Composite

Advertisement

From where I sit *by* Joe Marsh

Wrong "Train" of Thought

Most of us knew the streamliner stopped about four miles from town Thursday—but we didn't know *why* . . .

Seems the train was hurrying right along, then came the screeching of brakes—some fellow had pulled the Emergency Stop cord.

When the conductor asked him why he did it, he quickly replied, "The train was going much too fast—I wanted to get you to slow down."

From where I sit, that streamliner has been going at that speed for the past seven years with a perfect safety record and the passengers have always been pleased.

Now—along comes a fellow who wants the train to go at his speed. Some people are like that. Some would tell a neighbor how to practice his profession . . . others would begrudge a person's right to a glass of beer—even though they wouldn't dream of flashing a "Stop" sign on preferences for, say, milk, coffee or tea. Respecting the rights of others is the only way we can all keep "on the right track."

Joe Marsh

Copyright, 1953, United States Brewers Foundation

WOMAN'S AUXILIARY
TO THE
FLORIDA MEDICAL ASSOCIATION

OFFICERS

MRS. HERSCHEL G. COLE, President.....*Tampa*
MRS. THOMAS C. KENASTON, President-elect.....*Cocoa*
MRS. RICHARD F. STOVER, 1st Vice Pres.....*Miami*
MRS. NELSON A. MURRAY, 2nd Vice Pres.....*Jacksonville*
MRS. REAVES A. WILSON, 3rd Vice Pres.....*Sarasota*
MRS. TAYLOR W. GRIFFIN, 4th Vice Pres.....*Quincy*
MRS. ALBERT G. LOVE, IV, Recording Sec'y.....*Gainesville*
MRS. HERBERT B. LOTT, Correspd. Sec'y.....*Tampa*
MRS. SAMUEL S. LOMBARDO, Treasurer.....*Jacksonville*

COMMITTEE CHAIRMEN

MRS. CHARLES F. HENLEY, Finance.....*Jacksonville*
MRS. EDWARD F. SHAVER, Today's Health.....*Tampa*
MRS. ALVIN L. MILLS, Legislation.....*St. Petersburg*
MRS. C. RUSSELL MORGAN, JR., Public Relations....*Miami*
MRS. WILLIAM G. MERIWETHER, Reference.....*Plant City*
MRS. SHERREL D. PATTON, Civil Defense.....*Sarasota*
MRS. CARROLL V. HERRON, Projects.....*Daytona Beach*
MRS. JULIUS ALEXANDER, Program.....*Miami*
MRS. JAMES T. COOK, JR., Bulletin.....*Marianna*
MRS. GEORGE H. PUTNAM, Historian.....*Gainesville*
MRS. ANGUS D. GRACE, Parliamentarian.....*Fort Myers*
MRS. ALFONSO F. MASSARO, Revisions.....*Tampa*
MRS. JOHN E. MAINES, JR., Stu. Loan Fund....*Gainesville*
MRS. ARTHUR R. KNAUF, Medaux.....*Tampa*
MRS. CHARLES McD. HARRIS, JR., Study Group.....*W. P. Beach*
MRS. C. ROBERT DEARMAS, Auxiliary Writer for State Medical Journal.....*Daytona Beach*
MRS. EDWARD W. CULLIPHER, Stu. Nurse Recruit. *Miami*
MRS. LEFFIE M. CARLTON, JR., Hospitality.....*Tampa*

April Invitation

With the April meeting of the Florida Medical Association just around the corner, all plans are being completed in the smallest detail to insure program interest and scientific information, as well as entertainment for both the doctor and his wife.

It's a heart-warming thought to know how many people throughout the state are working to make this year a great success. Be sure to join the ladies while your doctor is occupied with his sessions. The annual Auxiliary meeting and luncheon takes up but one part of one day during that wonderful convention. If you are a member, be a good member by showing your interest in what the present group has accomplished as well as by showing courtesy to the elected group. If you are not a member, perhaps if you knew the aims and objectives and saw them in operation you might be interested in becoming a member.

In either case, each doctor's wife is cordially invited and warmly welcomed by the Woman's Auxiliary to the Florida Medical Association.

Mrs. C. Robert DeArmas

Annual Session
Woman's Auxiliary to
The Florida Medical Association
Hollywood, April 26-28, 1953

Medical Licenses Granted

Dr. Homer L. Pearson, Jr., Secretary of the State Board of Medical Examiners, has reported that of the 226 applicants who took the examination of the Board, held November 24 and 25, 1952, in Jacksonville, 202 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 202 successful applicants follow:

Abel, Bernard, Fort Monmouth, N. J. (Kansas City P. & S. 1942)
Abernathy, Thomas Eugene, Jacksonville (Tulane 1952)
Akerman, Joseph Lax, Orlando (Tulane 1951)
Allen, Marvin Salisbury, Hollywood (Emory 1948)
Alm, Bernard Theodore, Selfridge A.F.B., Mich. (Wayne 1935)
Anderson, Augustus Emmett, Jr., New Orleans (Tulane 1949)
Appleby, Leonard Willis, Brookline, Mass. (McGill 1948)
Arduino, Lino Joseph, Lake City (Marquette 1939)
Ayers, Sanford Emmett, Gainesville (Louisville 1931)
Ayre, J. Ernest, Miami (Alberta 1936)

Bailey, Jesse Kersey, Miami (Eclectic of Cincinnati 1920)
Baker, Kenneth Alvin, St. Petersburg (Illinois 1951)
Ballentine, Charles Nisley, Atlanta, Ga. (Michigan 1948)
Baptisti, Arthur, Jr., Hagerstown, Md. (Johns Hopkins 1932)
Barlow, Frank Aloysius, St. Petersburg (McGill 1930)
Bass, Billy Jack, Miami (Washington 1951)
Baum, Victor, New York (New York 1942)
Bernie, David Louis, Dayton, O. (Ohio State 1936)
Bernstein, Martin, Miami (Chicago Med. Sch. 1952)
Blake, Thomas Franklin, Miami (Jefferson 1948)
Bleicher, Jerome Edward, Omaha (Creighton 1945)
Bond, James Oliver, Sebring (Chicago 1950)
Bond, James Willis, Jacksonville (Indiana 1951)
Borow, Maurice, Fort Myers (Temple 1927)
Bovill, Edwin Gladstone, Detroit (Wayne 1924)
Bower, Robert Joseph, Miami (Jefferson 1951)
Brashear, Richard Irving, Columbus, O. (Cincinnati 1930)
Brock, Benjamin Lane, Orlando (Harvard 1923)
Brock, Charles Carlisle, Jr., Miami (Vanderbilt 1952)
Bryan, Herman Lawrence, Miami (Texas 1952)
Bullock, Henry Armistead, Jr., Jacksonville (Med. Coll. of Virginia 1948)
Burke, Charles Hulett, Columbus, Ga. (Emory 1952)
Burley, Dwight Bonner, Jr., Miami (Temple 1952)

Cagan, Maclyn, N. Arlington, N. J. (St. Andrews 1932)
Calderin, Victor Oscar, Miami (Havana 1945)
Caldwell, Frederic Ewald, Mary Esther (Western Reserve 1950)
Campbell, Meredith Fairfax, Miami (Columbia 1919)
Carron, Jonas, Staten Island, N. Y. (Michigan 1950)
Carson, Doris Newell, Jacksonville (Ohio State 1950)
Carter, Harvey Richard, Orlando (Georgia 1952)
Carver, James Clayton, Tampa (Indiana 1952)
Charpentier, Leonard A., Miami (Boston 1952)
Clark, Dorothy Twitchell, Orlando (Harvard 1952)
Clayton, James Merlin, Sr., Lakeland (Georgia 1952)
Cohen, Herman, Miami Beach (Tulane 1952)
Cook, Thomas Dakin, Hammond, Ind. (Louisville 1945)
Cooksey, Charles Dudley, Jacksonville (Louisiana State 1946)
Cooper, John Fenimore, Bay Pines (Tufts 1943)
Cordrey, Lee James, Philadelphia (Temple 1945)
Crawford, Alvin Smith, Mobile, Ala. (Georgetown 1949)
Creese, Philip Guy, Lake City (Harvard 1942)
Crispin, Maximilian Antonio, Hartford, Conn. (Temple 1941)
Culpepper, Stuart Pitner, Orlando (Maryland 1952)

Darby, Lee Hosch, Jacksonville (Georgia 1951)
DeLaney, Allen Young, Poplar Bluff, Mo. (Tulane 1940)

RECENT DENTAL LITERATURE ADVOCATES BAN ON THUMB SUCKING AND NAIL BITING

Cast from a children's dental clinic showing malocclusion due to thumb sucking

Authorities show developmental defects in dental occlusion when vicious habits are not treated. Children and adults alike are subject to these injurious mouth habits.

Nagging and rebuke are psychologically unsound and serve only to focus attention on the habit. For efficient treatment on a reflex basis, prescribe

Order from your pharmacist

Contains: Oleo Resin Capsicum, Aloe, Benzoin, Storax, Tolu Balsam, Soluble Pyroxylin and Alcohol 4.75%

BAN

ADVERTISED IN AMERICAN MEDICAL ASSOCIATION PUBLICATIONS

Professional samples available. WRITE TO:

PUREPAC CORPORATION
511 East 72nd Street • New York 21

The Earle Johnson Sanatorium

Announces the Association of

ROLAND E. TOMS, M.D.
A.P.A., F.A.M.A.

Diplomate of the American Board of Psychiatry and Neurology, formerly Chief of Neuro-Psychiatric Services Veterans Administration Hospitals at Palo Alto, California, Brooklyn, New York, and Jackson, Mississippi.

as

Psychiatrist-in-Chief

For the care of nervous, mental, senile, alcoholic, addicted and custodial cases.

P. O. Box 105 **Telephone 3-3369**

Meridian, Mississippi

Delmonico, Peter Alexander, Belmont, Mass. (Kansas City P. & S. 1943)
Dolison, Dean Marlow, St. Petersburg (Harvard 1948)
Duckett, Howard Casey, Jr., Durham, N. C. (Duke 1944)
Duke, Joseph Edward, Gadsden, Ala. (Alabama 1952)

Eney, Irving Port, Miami (Jefferson 1952)
Epstein, Byron David, Miami (Tennessee 1949)

Fern, Burton Hoffman, Maitland (New York 1948)
Fessenden, Clarence Leon, Winter Park (Syracuse 1910)
Fieldman, E. Jay, Palm Beach (State U. of New York 1951)
Fein, Bernard, Newark, N. J. (Cornell 1924)
Fischer, Ralph Laurence, Jr., Philadelphia (Temple 1952)
Fitz, Thomas Edmunds, Smyrna, S. C. (Duke 1950)
Flax, Ralph Wilner, Long Beach, N. Y. (St. Andrews 1933)
Ford, James Arthur, Jacksonville (Johns Hopkins 1950)
Forkosh, Sidney Richard, Venice (Illinois 1930)
Friedrich, Martin, Brooklyn (Long Island Med. Coll. 1925)

Garrett, Samuel Randolph, Orlando (South Carolina 1952)
Gatliff, Benjamin Franklin, Orlando (Georgia 1952)
Getz, Alvin Maxwell, Miami (Illinois 1949)
Giesen, Andrew Frederick, Jr., Radford, Va. (Tulane 1952)
Glasson, Lancelot George Getty, Miami (Marquette 1947)
Gonzalez, Arturo Gonzalo, Middletown, N. Y. (Havana 1948)
Goodrich, Albert, Easton, Conn. (Indiana 1941)
Grawey, Gerald William, Miami (St. Louis 1952)
Greiwe, Thomas Henry, Tampa (Cincinnati 1949)
Griot, Albert Jacob, St. Louis (St. Louis 1910)

Haas, Stuart Leslie, Melbourne (Virginia 1947)
Hagel, Donald Richard, Jacksonville (Nebraska 1951)
Haltiwanger, Earl, Jr., Durham, N. C. (Duke 1951)
Hamilton, Edward Lee, Orlando (Duke 1950)
Harding, Paul Christensen, Orlando (Utah 1952)
Harrington, Francis Joseph, Tampa (Tufts 1947)
Harrison, Lloyd Bratton, Jr., Baltimore (Virginia 1945)
Hattaway, Leonard Franklin, Lafayette, La. (Tulane 1946)
Hawk, Judson Louis, Jr., Miami (Georgia 1952)
Henrichs, Ann, Miami (Washington 1950)
Hills, John Robert, Jacksonville (Emory 1952)
Hodge, James Brennan, Jr., Sulphur, La. (Louisiana State 1943)
Hoffman, Milton Joseph, Miami (Tulane 1952)
Houston, Clarence Harold, Jacksonville (Georgia 1950)
Howarth, Joseph Cornall, Orlando (Victoria 1943)
Hoyt, Thomas Larkin, Pensacola (Hahnemann 1947)
Hubbell, David Smith, Durham, N. C. (Duke 1946)
Hulet, William Henry, Miami (Pennsylvania 1951)
Hutchison, William Jelier, Augusta, Ga. (Northwestern 1946)

Isaacson, Marvin Gerald, San Antonio, Tex. (Boston P & S 1945)

Jackson, Kenneth Watson, Miami (St. Louis 1952)
Jaffe, Edward B., Jackson, Miss. (Chicago Med. Sch. 1947)
Johnston, Marvin Harlan, Green Cove Springs (Georgia 1946)
Jones, Kenneth Goss, Little Rock, Ark. (Arkansas 1943)
Joyce, Reid Petree, Dayton, O. (Pennsylvania 1932)

Kaufman, Arthur L., Fort Dix, N. J. (Illinois 1948)
Kebe, George Bengali (Col.) Enterprise, Ala. (Meharry 1938)
Keeley, Robert Louis Anthony, Durham, N. C. (Virginia 1944)
Kenet, David S., Lakeland (Vermont 1947)
Kennedy, Joseph Thomas, Miami (Cincinnati 1952)
Kraemer, Eugene Antoine, Jr., Tampa (Tulane 1947)
Kratina, Frederic Karl, Miami (Georgia 1952)
Kreitman, Julius, Brooklyn (Bellevue Hosp. Med. Coll. 1952)
Kullman, Donald Alan, Miami Beach (New York 1952)

Langstaff, John Merit, Miami (Loyola 1944)
Lesser, Milton Edgar, Coral Gables (Yale 1950)
Levinson, Melvin, Miami (Chicago Med. Sch. 1952)
Lewis, Richard Samuel, Miami (Indiana 1950)
Lincoln, John Luther, Quincy (Buffalo 1939)
Litman, Arthur Gene, Miami (Minnesota 1952)
Longino, Frank Henry, Durham, N. C. (Duke 1947)
Lovejoy, Elizabeth Knott, Hialeah (Wisconsin 1943)
Lowenstein, Bertrand Ernst, Miami (Columbia 1942)
Lucas, Frederick Herman, Orlando (Wayne 1952)

Marchetto, Louis James, Pittsburgh (Pittsburgh 1951)
Marrero, Emilio Joseph, Perkiomenville, Pa. (California 1949)
Matthews, Joseph George, Orlando (Jefferson 1952)
Maxey, Edward Stanton, Huntington, W. Va. (Bowman Gray 1950)
McCain, James Robert, Jacksonville (Tennessee 1951)
McCarthy, William Paul, Miami (Temple 1938)
McClow, Marvin Vierl, Jacksonville (Iowa 1945)
McFadden, James Marshall, Lafayette, Ind. (Indiana 1936)
Meitus, Marvin L., Miami Beach (Cincinnati 1946)
Merchant, John Proctor, Jr., Miami (Alabama 1952)
Mezer, Joseph Henry, Biscayne Beach (Tufts 1921)
Monaco, Angelo Ralph, Columbus, Ga. (Georgetown 1938)
Morton, Glenn Herbert, Lake Harbor (Syracuse 1947)
Moss, Herman, Jacksonville (Marquette 1947)

Neely, Richard Claude, Jr., Ravenna, O. (Western Reserve 1940)
Nelson, Harry Charles, Jr., Miami (Med. Evangelists 1944)

• In MIAMI
SANITARIUM
Medical Hospital American Plan
Hotel for Patients and their families.
REST, CONVALESCENCE, ACUTE and
CHRONIC MEDICAL CASES. Elderly
People and Invalids. *FREE Booklet!*

Acres Tropical Grounds, Delicious Meals,
Res. Physician, Grad. Nurses, Dietitian.

SUN-RAY PARK HEALTH RESORT

Mild Mental Cases,
Drug and Alcoholics
in Separate Building

Oransky, Philip, Miami (Chicago Med. Sch. 1950)
Orr, Alva Denton, Lake City (Virginia 1944)

Pennington, Edna Scott, Nashville, Tenn. (Minnesota 1924)
Perry, Benton Bloch, Miami (Maryland 1952)
Peterson, Wesley LeRoy, Jr., Cheyenne, Wyoming (Northwestern 1948)
Pincus, Isidore, Newark, N. J. (Long Island Coll. of Med. 1932)
Plunket, Daniel Clark, Richmond, Va. (Emory 1952)

Rachlin, Bernard, Philadelphia (Washington 1952)
Rawls, George Hosea (Col.), Gainesville (Howard 1952)
Reinherz, Albert, Lantana (Boston P & S 1949)
Ring, Bartholomew Hernad, Lake Placid, N. Y. (Prague 1920)
Rosen, Robert Reuben, West Jefferson, N. C. (Maryland 1949)
Ross, John Bruce, Jacksonville (Johns Hopkins 1940)
Rothermel, Robert Earl, St. Petersburg (Temple 1935)
Rozum, John K., Cumberland, Md. (Maryland 1931)
Rubin, Seymour Walter, Miami Beach (Glasgow 1939)
Ruzow, Stanley Joseph, Miami (Ohio State 1951)

Scott, George Edward, Athens, Ga. (Vanderbilt 1952)
Scripter, Lyman Jay, Tampa (Pittsburgh 1949)
Seminario, Alfred Peter, Camp Chaffee, Ark. (Buenos Aires 1941)
Sheahan, Robert Charles, Miami (Ohio State 1950)
Silverman, Benjamin K., West Palm Beach (Maryland 1948)
Simmonds, Harold E., Richmond Hill, N. Y. (Tufts 1928)
Simon, Herbert James, New York (Loyola 1931)
Simpson, Loleta Eliza, Loma Linda, Calif. (Med. Evangelists 1932)
Singer, John Edward, Cincinnati (Cincinnati 1936)
Smaller, Ben I., Chicago (Illinois 1947)
Smith, Daniel Curtis, Miami (Cincinnati 1952)
Smith, Edward Patrick, Jr., Cambridge, Mass. (Maryland 1946)
Smith, William Paul, Pittsburgh (Hahnemann 1948)
Sorel, Otto George, Camp Chaffee, Ark. (Lausanne 1939)
Spivey, Lee Myrl, Lakeland (Emory 1951)
Steussy, Calvin Nicklaus, Miami (Wisconsin 1951)
Stitt, Richard Marks, Cleveland (Duke 1946)
Stratton, Albert F., Jr., Leesburg (Tulane 1952)
Strozier, Thomas Benjamin, Miami (Georgia 1952)
Sullenberger, John William, Tallahassee (Duke 1952)
Sullivan, Edward Martin, Philadelphia (Temple 1952)

Tainter, Rolfe, Winter Park (Northwestern 1917)
Thigpen, Frederick Bruce, Augusta, Ga. (Georgia 1948)
Till, Walter Harmon, Miami (Tulane 1952)
Tindall, Robert Leslie, Miami (Indiana 1952)
Turke, George Joseph, Jr., Coral Gables (Illinois 1950)

Waltz, Frank Clinton, Punta Gorda (Indiana 1952)
Ward, Robert Barnet, Shaw AFB, S. C. (Buffalo 1947)
Watkins, Maltby Foxworthy, Dayton, O. (Louisville 1951)
Webb, Clarence Foreman, Robins AFB, Georgia (Northwestern 1946)
Webb, William Christopher, Montgomery, Ala. (Marquette 1948)
Weinberger, Howard Arnold, New York (Johns Hopkins 1940)
Whalen, William P., New York (Cornell 1934)
Wharton, Dwight J., Jacksonville (Washington 1924)
White, LaVere Gaillard, Staten Island, N. Y. (Iowa 1945)
Wilcoxon, George Mansell, Fort Lauderdale (Chicago 1935)
Wilkinson, Albert Harrison, Jr., Jacksonville (Jefferson 1952)
Witt, Governor Martin, Lake Worth (Western Reserve 1951)
Wonka, Warren Joseph, New Orleans (Harvard 1949)

Yantis, Earl Edward, Atlanta, Ga. (Emory 1951)
Young, Robert Ulrich, Atlanta, Ga. (Duke 1952)

Zeller, Frank, Jr., Detroit (Indiana 1949)
Zimont, Raymond D., Constantine, Mich. (Illinois 1937)
Zundell, Warren, Coral Gables (New York 1949)

Cook County Graduate School of Medicine

POSTGRADUATE COURSES — 1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting April 13, April 27, May 11. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting June 1. Surgical Anatomy & Clinical Surgery, Two Weeks, starting June 15, August 17. Gallbladder Surgery, Ten Hours, starting April 20. Surgery of Colon & Rectum, One Week, starting April 13. General Surgery, One Week, starting May 4. General Surgery, Two Weeks, starting April 20. Thoracic Surgery, One Week, starting June 8. Breast & Thyroid Surgery, One Week, starting June 22. Esophageal Surgery, One Week, starting June 22. Fractures & Traumatic Surgery, Two Weeks, starting June 15.

GYNECOLOGY—Intensive Course, Two Weeks, starting April 20. Vaginal Approach to Pelvic Surgery, One Week, starting May 4.

OBSTETRICS—Intensive Course, Two Weeks, starting June 8.

PEDIATRICS—Congenital Heart Disease, Two Weeks, starting May 18. Cerebral Palsy, Two Weeks, starting June 15.

MEDICINE—Intensive General Course, Two Weeks, starting May 4. Electrocardiography & Heart Disease, Two Weeks, starting July 13. Allergy, One Month and Six Months, by appointment.

CYSTOSCOPY—Ten day Practical Course starting every two weeks.

DERMATOLOGY—Intensive Course, Two Weeks starting May 11.

Teaching Faculty:

Attending Staff of Cook County Hospital

Address:

Registrar, 707 South Wood Street,

Chicago 12, Illinois

THE
MEDICAL PROTECTIVE
COMPANY
FORT WAYNE, INDIANA

PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899

specialized service
assures *"know-how"*

ST. PETERSBURG Office:
Calvin Bimer, Rep.,
240 Mateo Way, Snell Isle,
Telephone 73-289

Allen's Invalid Home

MILLEDGEVILLE, GA.

Established 1890
For the treatment of
NERVOUS AND MENTAL DISEASES

Grounds 600 Acres
Buildings Brick Fireproof
Comfortable Convenient
Site High and Healthful

E. W. ALLEN, M.D., *Department for Men*
H. D. ALLEN, M.D., *Department for Women*
Terms Reasonable

CONVENTION PRESS

218 WEST CHURCH STREET
JACKSONVILLE
FLORIDA

Commercial and
Publication
Printing

BRAWNER'S SANITARIUM

ESTABLISHED 1910

SMYRNA, GEORGIA

(Suburb of Atlanta)

For the Treatment of

Psychiatric Illnesses and Problems of Addiction

Psychotherapy, Convulsive Therapy, Recreational and Occupational Therapy
Modern Facilities

Custodial Care for a Limited Number of Elderly Patients at Monthly Rate

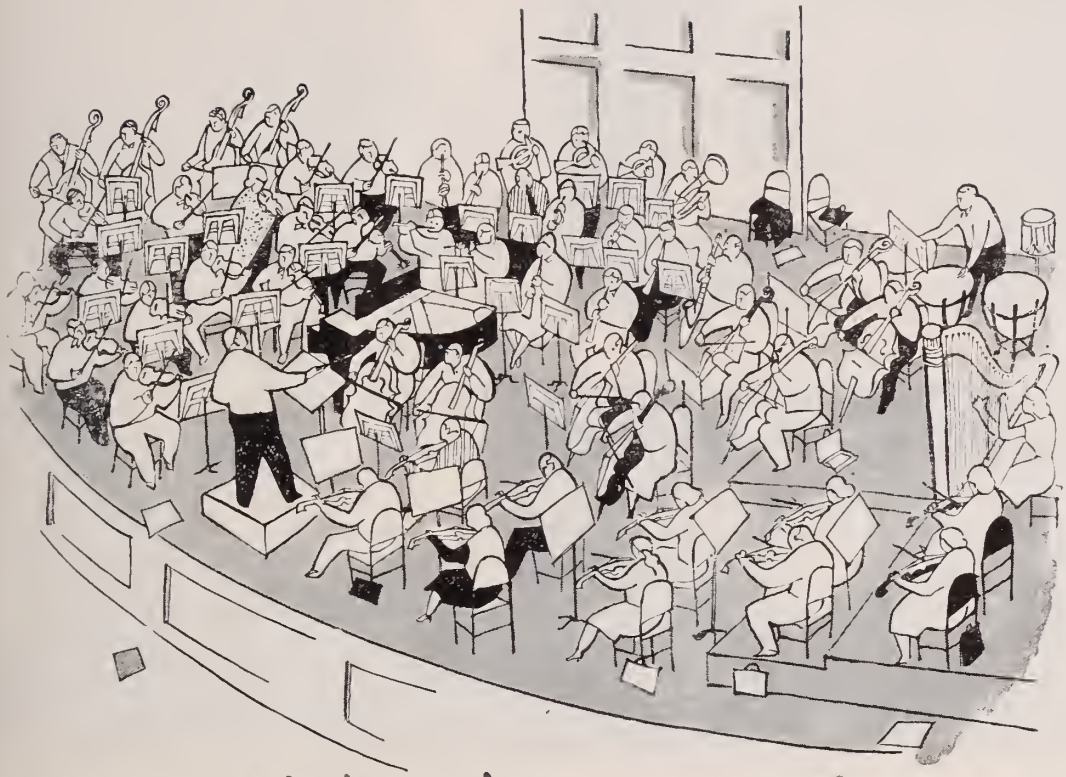
JAS. N. BRAWNER, M.D.
Medical Director

Jas. N. BRAWNER, JR., M.D.
Assistant Director and
Superintendent

ALBERT F. BRAWNER, M.D.
Resident Superintendent

P. O. Box 218

Phone 5-4486



they could stage their own symphony

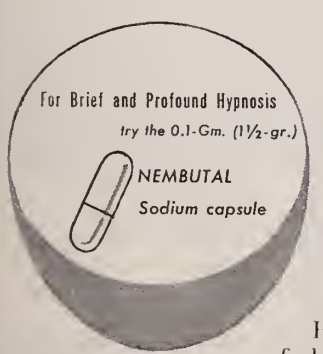
. . . all the patients who represent the 44 uses for short-acting

NEMBUTAL®

Ever wonder why one drug should survive 23 years of clinical experience (when a lifetime for many is only about five)? Why it should account for 598 published reports? Or more than 44 clinical uses?

Short-acting Nembutal (Pentobarbital, Abbott) is the drug. The reasons why?

1. Short-acting Nembutal can produce any desired degree of cerebral depression—from mild sedation to deep hypnosis
2. The dosage required is small—only about half that of many other barbiturates.
3. There's less drug to be inactivated, shorter duration of effect, wide margin of safety and usually no morning-after hangover.
4. In equal oral doses, no other barbiturate combines quicker, briefer, more profound effect.



How many of short-acting Nembutal's 44 uses have *you* tried? You'll find details on all in the booklet, "44 Clinical Uses for Nembutal." Write Abbott Laboratories, North Chicago, Illinois. Abbott

BISCAYNE HOSPITAL

6339 Biscayne Blvd.
MIAMI 38, FLORIDA

Members of the Dade County Medical Association are acquainted with the high type of service rendered.

David Collins, Superintendent

Registered, American Medical Association
Phone 7-4544

MIAMI MEDICAL CENTER

P. L. DODGE, M.D.
Medical Director and President

1861 N. W. South River Drive
Phones 2-0243 — 9-1448

A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures — Psychotherapy, Insulin, Electroshock, Hydrotherapy, Diathermy and Physiotherapy when indicated. Adequate facilities for recreation and out-door activities. Cruising and fishing trips on hospital yacht.

Information on request
Member American Hospital Association

BALLAST POINT MANOR

Care of Mild Mental Cases, Senile Disorders
and Invalids
Alcoholics Treated

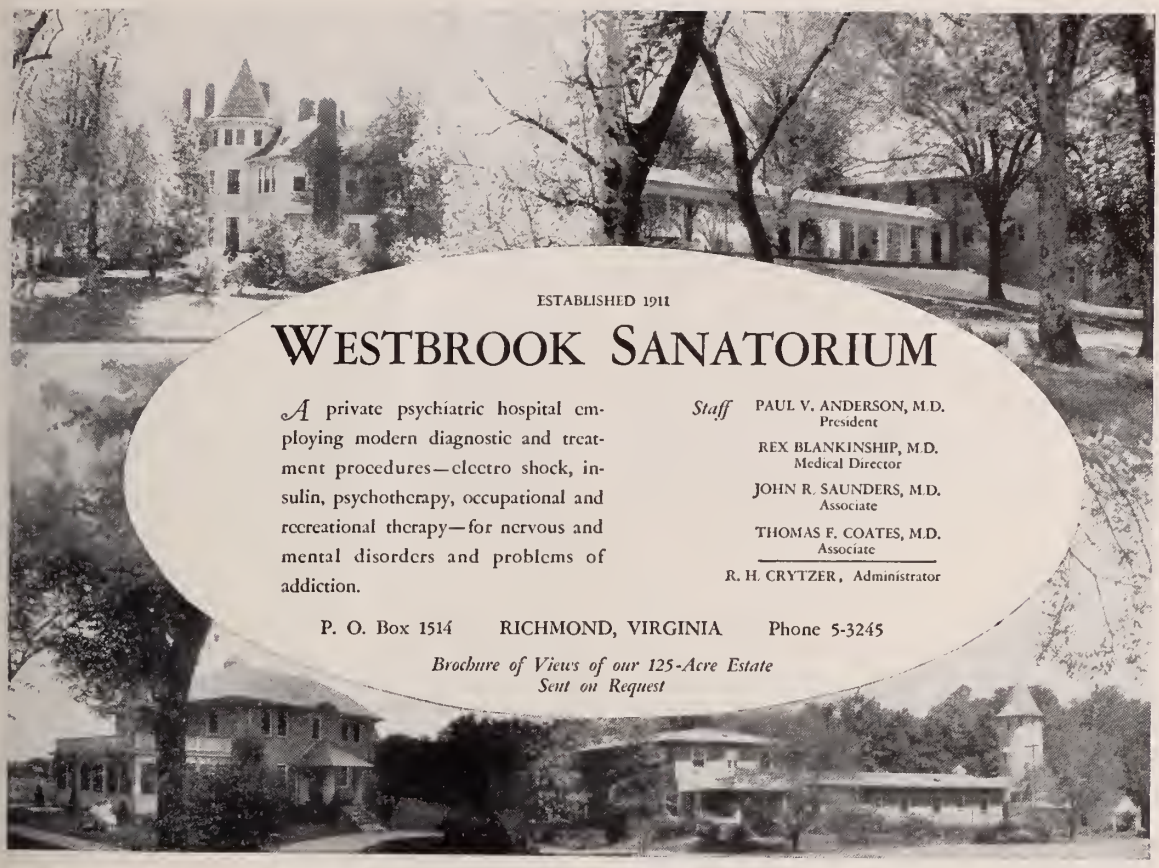
Aged adjudged cases will be accepted on either permanent or temporary basis.

ACCREDITED HOSPITAL FOR NEUROLOGICAL PATIENTS by
American Medical Assn.
American Hospital Assn.
Florida Hospital Assn.

5226 Nichol St.
Telephone 62-2332

DON SAVAGE
Owner and Manager

P. O. Box 10368
Tampa 9, Florida



ESTABLISHED 1911

WESTBROOK SANATORIUM

A private psychiatric hospital employing modern diagnostic and treatment procedures—electro shock, insulin, psychotherapy, occupational and recreational therapy—for nervous and mental disorders and problems of addiction.

Staff
PAUL V. ANDERSON, M.D.
President
REX BLANKINSHIP, M.D.
Medical Director
JOHN R. SAUNDERS, M.D.
Associate
THOMAS F. COATES, M.D.
Associate
R. H. CRYTZER, Administrator

P. O. Box 1514 RICHMOND, VIRGINIA Phone 5-3245

Brochure of Views of our 125-Acre Estate Sent on Request

HILL CREST SANITARIUM

FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

Thoroughly modern in architecture and construction. Eight departments — affording proper classification of patients. All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

James A. Becton, M.D., Physician-in-charge James Keene Ward, M.D., Associate Physician

P. O. Box 2896, Woodlawn Station, Birmingham, Alabama **Phones 9-1151 and 9-1152**

TUCKER HOSPITAL, INC.

212 West Franklin Street

RICHMOND, VIRGINIA

A private hospital accepting for diagnosis and treatment organic neurological conditions, selected psychiatric and alcoholic cases, metabolic disturbances of an endocrine nature, individuals who are having difficulty with their personality adjustments, and children with behavior problems. Patients with general medical disorders admitted for treatment under our staff of visiting physicians.

Under the Professional Charge of

DR. HOWARD R. MASTERS,

DR. JAMES ASA SHIELD AND ASSOCIATES

HIGHLAND HOSPITAL, INC.

FOUNDED IN 1904

Asheville, North Carolina

AFFILIATED WITH DUKE UNIVERSITY

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a sixty-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D.,
Diplomate in Psychiatry
Medical Director

ROBT. L. CRAIG, M.D.,
Diplomate in Neurology and Psychiatry
Associate Director

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Medical Association	Robert B. McIver, Jacksonville	Samuel M. Day, Jacksonville	Hollywood, Apr. 26-29, '53
Medical Districts	Eugene G. Peek, Jr., Ocala	Council Chairman	
orthwest	Francis M. Watson, Marianna	Benjamin A. Wilkinson, Tallahassee	Tallahassee, 1953
ortheast	William C. Thomas, Jr., Gainesville	Eugene L. Jewett, Orlando	St. Augustine, 1953
outhwest	Emmett E. Martin, Haines City	Hugh G. Reaves, Sarasota	Tampa, 1953
outheast	Erasmus B. Hardee, Vero Beach	Donald W. Smith, Miami	West Palm Beach, 1953
Specialty Societies			
ny of General Practice	Edward F. Shaver, Tampa	Frank T. Linz, Tampa	Hollywood, Apr. 26, '53
Society	Nelson Zivitz, Miami Beach	Solomon D. Klotz, Orlando	" "
esiologists, Soc. of	John T. Stage, Jacksonville	Breckenridge W. Wing, Orlando	" "
r, Am. Coll. Chest Phys.	Alexander Libow, Miami Beach	DeWitt C. Daughtry, Miami	" "
and Syph., Soc. of	Lewis Capland, Miami Beach	Morris Waisman, Tampa	" "
Officers' Society	George W. Edwards, II, Orlando	Lorenzo L. Parks, Jacksonville	" "
rial & Railway Surgeons	John H. Mitchell, Jacksonville	William H. Chapman, Jacksonville	" "
ogy & Psychiatry	W. Tracy Haverfield, Miami	Roger E. Phillips, Orlando	" "
l Gynec. Society	Dorothy D. Brame, Orlando	J. Champneys Taylor, Jacksonville	" "
il. & Otol., Soc. of	Joseph W. Taylor, Sr., Tampa	Carl S. McLemore, Orlando	" "
edic Society	Arthur H. Weiland, Coral Gables	Edward W. Cullipher, Miami	" "
logists, Society of	Robert J. Poppiti, Miami Beach	Alfred E. Cronkite, Fort Lauderdale	" "
ic Society	Charlotte C. Maguire, Orlando	Wesley S. Nock, Coral Gables	" "
logic Society	Alex. E. Rosenberg, Miami Bch.	George Williams, Jr., Miami	" "
ogical Society	Thomas H. Lipscomb, Jacksonville	A. Judson Graves, Jacksonville	" "
ical Society	George H. Putnam, Gainesville	David W. Goddard, Daytona Beach	" "
r—			
c Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 6, '53
d Banks, Association	Donald W. Smith, Miami	Mr. J. M. Potts, Miami	Miami, May, 1953
Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Miami, Dec. 3. '53
Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 29, '53
er Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Hollywood, Apr. 26, '53
tal Society, State	W. G. McLeod, D.D.S., Pensacola	Coleman Brown, D.D.S., Tampa	St. Petersburg, Apr. 20-23, '53
t Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
pital Association	Mr. T. F. Little, Daytona Beach	Mr. Tracy B. Hare, Miami	Miami, Nov. '53
ical Examining Board	Ralph B. Spires, DeFuniak Springs	Homer L. Pearson, Jr., Miami	Jacksonville, June 28-30, '53
ical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 22-27, '53
ses Association, State	Mrs. Mary Livingston, W. P. Beach	Mrs. Idalyn Lawthon, Tampa	Tampa, Nov. '53
rmaceutical Association, State	Mr. Clyde Morris, Daytona Beach	Mr. R. Q. Richards, Ft. Myers	St. Petersburg, May, '53
lic Health Association	Mr. Angus Laird, Tallahassee	Mr. Fred B. Ragland, Jacksonville	Tampa, 1953
erculosis & Health Assn.	Leffie M. Carlton, Jr., Tampa	Mrs. L. C. Conant, Fort Myers	Jacksonville, May 14-15, '53
nan's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	Hollywood, Apr. 26-28, '53
an Medical Association	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	New York, June 1-5, '53
A. Clinical Session	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	St. Louis, Dec. '53
rn Medical Association	Walter C. Jones, Miami	Mr. C. P. Loranz, Birmingham	Atlanta, 1953
na Medical Association	B. W. McNease, Fayette	Douglas L. Cannon, Montgomery	Birmingham, Apr. 16-18, '53
a, Medical Assn. of	C. F. Holton, Savannah	Mr. Sid Wrightsman, Atlanta	Savannah, May 10-13, '53
ospital Conference	Mr. Norman Losh, Orlando	Mr. D. O. McClusky, Tuscal'sa, Ala.	New Orleans, April 8-10, '53
astern Allergy Assn.	Clarence Thomas, Nashville, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Nashville, May 15-16, '53
astern, Am. Urological Assn.	William Miner, Covington, Ky.	Sidney Smith, Raleigh, N. C.	
astern Surgical Congress	J. R. Young, Anderson, S. C.	B. T. Beasley, Atlanta	Birmingham, Mar. 8-11, '54
oast Clinical Society	Hays Zieman, Mobile, Ala.	William Atkinson, Mobile, Ala	Mobile, Oct., '53

MIAMI RETREAT SANATORIUM

FOUNDED 1927

For Nervous and Mental Disorders. Alcohol and Drug Addiction

STAFF OF EIGHT NEUROPSYCHIATRISTS
New X-Ray Diagnostic Treatment Facilities
Comfortable AIR-CONDITIONED rooms. suites

79TH STREET AT MIAMI AVENUE
MIAMI 38, FLORIDA

Phone 7-1824

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS TOTAL	MEMBERS PAID	COUNCIL
A	Bay	Harold E. Wager, M.D. Box 984 Panama City	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	1st Tuesday 7:30 P.M.	24	19	
	Escambia *Santa Rosa*	Alvin L. Stebbins, M.D. 621 N. O St. Pensacola	Paul F. Baranco, M.D. 608 Blount Bldg. Pensacola	2nd Tuesday 8:00 P.M.	88	85	
	Franklin-Gulf	Photis J. Nichols, M.D. Apalachicola	Terry Bird, M.D. Apalachicola	Last Wednesday except Dec. & July	7	100%	A-1-54 Francis M Watson, M Mariann
	Jackson-Calhoun	Grayson C. Snyder, M.D. Floyd Bldg. Blountstown	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	19	18	
	Walton-Okaloosa	Edgar H. Myers, M.D. DeFuniak Springs	William D. Cawthon, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	17	100%	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		5	100%	
B	Columbia **Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	10	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	T. Bert Fletcher, Jr., M.D. 516 N. Adams St. Tallahassee	Quarterly 7:30 P.M.	59	50	
	Suwannee	Hiram B. Curry, M.D. Jasper	Edward G. Haskell, Jr., M.D. Branford	1st Saturday 9:30 A.M.	8	6	A-2-53 Benjamin Wilkinson, Tallahass
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		4	3	
	Taylor **Dixie, Lafayette*	Mark E. Adams, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	4	1	249
C	Alachua **Bradford, Gilchrist, Union*	F. Emory Bell, M.D. Box 113 Gainesville	Winston L. Summerlin, M.D. 111 S. W. 3rd St. Gainesville	2nd Tuesday 8:00 P.M.	46	41	
	Duval **Clay*	W. W. Rogers, M.D. 962 Main St. Jacksonville	John T. Stage, M.D. 2033 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	256	160	
	Marion **Levy*	Eugene G. Peek, Jr., M.D. Box 248 Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	27	17	B-3-54 William Thomas, Jr. Gainesvi
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	12	11	
	Putnam	Bernard E. Kane, M.D. Box 216 Crescent City	James A. Long, Jr., M.D. 1001 Main St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
	St. Johns	John M. Canakaris, M.D. Box 295 Bunnell	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
D	Brevard	Laurent L. LaRoche, M.D. 526 Brevard Ave. Cocoa	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	2nd Tuesday	25	22	
	Lake **Sumter*	John D. Bloom, M.D. Groveland	J. Basil Hall, M.D. Tavares	1st Wednesday 7:30 P.M.	27	24	
	Orange **Osceola*	G. Tayloe Gwathmey, M.D. 417 E. Robinson Ave. Orlando	Andrew W. Townes, Jr., M.D. 717 N. Magnolia Ave. Orlando	3rd Wednesday 8:00 P.M.	165	149	B-4-5. Eugene L. Jew Orlan
	Seminole	Wade H. Garner, M.D. Box 219 Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	18	100%	
	Volusia **Flagler*	Morris B. Seltzer, M.D. 614 N. Peninsula Dr. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	83	64	683
	Hillsborough	Arthur R. Knauf, M.D. 706 Franklin St. Tampa	Julien C. Pate, Jr.,M.D. 1105 First Nat. Bk. Bldg. Tampa	1st Tuesday 8:00 P.M.	178	142	
	Manatee	William D. Sugg, M.D. Bradenton Bank Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	19	14	
	Pasco-Hernando-Citrus	Karl T. Humes, M.D. Box 157 Bushnell	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	18	100%	C-5-5. Hugh G. Rea Sarasc
	Pinellas	Everett M. Harrison, M.D. 1601 N. Ft. Harrison Ave. Clearwater	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Mon. Even Mo. 1st Fri. Odd Mo. 6:00 P.M.	197	189	
	Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	Melvin M. Simmons, M.D. 816 Florasota Gardens Sarasota	2nd Tuesday 8:30 P.M.	47	8	
	DeSoto-Hardee-Highlands-Glades	Wesley S. Pyatt, M.D. Bowling Green	Merle C. Kayton, M.D. Wauchula	2nd Tuesday 8:00 P.M.	25	23	
	Lee-Charlotte-Collier-Hendry	Ernest Bostelman, M.D. 201 Pythian Bldg. Fort Myers	Harry Fagan, Jr., M.D. 310 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	29	100%	C-6-5 Emmet Martin. Haines
	Polk	Jere W. Annis, M.D. Box 1021 Lakeland	James T. Shelden, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	97	84	610
D	Indian River	John P. Gifford, M.D. 1625 Osceola Blvd. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	6	
	Palm Beach	Graham W. King, Jr., M.D. Box 505 Delray Beach	David A. Newman, M.D. 175 Bradley Pl. Palm Beach	3rd Monday 8:00 P.M.	121	113	D-7-5 Erasmu Hardee, Vero B
	St. Lucie-Okeechobee-Martin	John T. McDermid, M.D. 337 N. 4th St. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	15	12	
	Broward	Claus A. Peterson, M.D. 312 Blount Bldg. Ft. Lauderdale	James M. Weaver, M.D. Box 4084 Ft. Lauderdale	4th Tuesday 8:00 P.M.	93	78	
	Dade	Ralph W. Jack, M.D. 1700 Biscayne Blvd. Miami	Walter W. Sackett, Jr., M.D. 2500 Coral Way Miami	1st Tuesday 8:30 P.M.	625	413	D-8- Donald W. S Mia
	Monroe	Joseph L. G. Lester, Jr., M.D. 422 Fleming St. Key West	Allen S. Shepard, M.D. 638 United St. Key West	2nd Thursday 8:00 P.M.	15	7	87

Tota

A Biological Refrigerator

DESIGNED FOR MODERN MEDICAL STORAGE

Dillon Lilly presents a new triumph of engineering skill that assures better, safer storage of biological drugs and serums. The new streamlined MODEL 200-B biological refrigerator is especially designed for the exclusive needs of doctors, dentists and hospitals. The MODEL 200-B not only stores biologicals and serums but keeps them safely until they are ready for use.

AN ASSET TO ANY PHYSICIAN'S OFFICE

Beautifully modern compact design with full length door provides large storage space of 3 cubic feet. All steel fiber glass insulated cabinet with gleaming white enamel exterior. Interior contains freezing section with two ice-cube trays, 14 cubes each — finger-tip control pull-out drawer — and two roomy expanded metal shelves — easily removed shelves offer flexibility for changing storage needs. Hermetically sealed refrigeration unit keeps out dirt, moisture — never needs oiling. Operates quietly and economically on 110 volts, 60 cycle A.C. current.

MEMBER

AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A. Quality and Service

Anderson Surgical Supply Co.

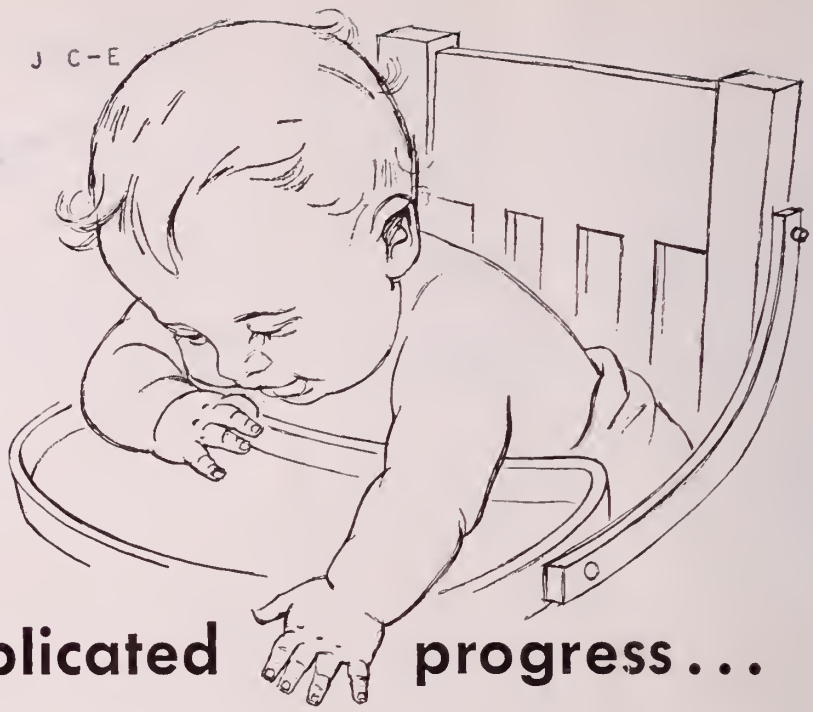
Established 1916

Telephone 5-2560
40-42 W. DUVAL STREET
P. O. Box 1799
JACKSONVILLE, 1, FLORIDA

Telephone M-8504
1101-1105 TAMPA STREET
P. O. Box 1223
TAMPA 1, FLORIDA

Telephone 7-4589
21 3rd STREET N.
ST. PETERSBURG, FLORIDA

NEW YORK ACADEMY OF MEDICINE
2 E 103RD ST
NEW YORK N Y 29
2
J C-E



uncomplicated progress . . .

Tolerance of feedings	good
Incidence of digestive disturbances	low
Growth response	satisfactory
Discontinuation of night feeding	early
Health and development	excellent

The uncomplicated nutritional progress[1] of infants fed Lactum® speaks for its sound rationale. Lactum is Mead's liquid formula made from whole milk and Dextri-Maltose.® It provides generous milk protein for sturdy growth and sound tissue structure, with sufficient calories to spare protein and meet the infant's energy needs.

Lactum is convenient and easy to prepare—simply mix equal parts of Lactum and water for a formula supplying 20 calories per fluid ounce.

1. Frost, L. H., and Jackson, R. L.: J. Pediat. 39: 585-592, 1951.

Lactum

MEAD JOHNSON & COMPANY
Evansville 21, Ind., U. S. A.

MEAD

Local Representative: Roger J. McElroy, 3181 McDonald Street, Coconut Grove 33, Florida, 4-4124.

The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXIX MAY, 1953 No. 11

IN THIS ISSUE

Adams-Stokes Syndrome
Sidney Grau

Evaluating Fluid and Electrolyte Therapy
John H. Kay and Alton Ochsner

Effects of Drugs on Circulation and Metabolism
Peritz Scheinberg

Fixation of Fractures of Long Bones
John T. Ellis and Samuel W. Windham

MAY - 8 1953
LIBRARY

OFFICIAL PUBLICATION OF THE
FLORIDA MEDICAL ASSOCIATION

Parke, Davis & Company announces a new series o

THEME: "In the hands of you

TIME

WESTERN UNION

YOUR HEART

Ever see a "telegram" from your heart?

PARKE, DAVIS & CO.

SATURDAY EVENING POST

PARKE, DAVIS & CO.

LIFE

DO YOU KNOW THIS MAN?

HIS NEGLIGENCE IS CAUSING THOUSANDS OF DEATHS FROM HEART DISEASE

RIGHT HAND

LEFT HAND

PARKE, DAVIS & CO.

Advertisements addressed to the general public . . .

"Physician, you're in good hands"

Neglect . . . delay. How many times, doctor, have you cared for patients . . . whose hope of recovery might have been bright indeed . . . *but for neglect or delay in seeking your help?*

Undoubtedly, this occurs so often . . . and usually with such tragic consequences . . . that many physicians view it as the greatest problem facing medical science today.

Moreover, this problem may assume even greater significance with the rising incidence of the degenerative diseases. For in these conditions, neglect and delay, as you well know, are *directly* responsible for a heavy toll of life.

We believe you will agree that this problem deserves increased and continuing emphasis. This is why Parke-Davis will publish, throughout 1953, a series of advertisements on the *patient's responsibility* in medical care.

These advertisements, four of which are reproduced here, will appear in leading magazines reaching millions of families. In them, this central theme will be emphasized:

That every individual, if he wants his physician's most effective help, must meet the doctor halfway. *He must not ignore symptoms, or delay treatment. He must act promptly . . . and be made to realize that "in the hands of your physician, you're in* good *hands."*

In addition, the advertisements will stress the fact that medicine has a vast store of new knowledge . . . and that this knowledge is constantly increasing through research by physicians, hospitals, public and private health organizations, and pharmaceutical companies.

A word about the preparation of these advertisements: They have been carefully written to avoid both the possibility of stimulating hypochondria and encouraging self-diagnosis. Equally important, the advertisements make no claims that might cause undue optimism or raise false hopes. We believe these are just the type of informative messages you will want your patients to read. Our efforts will be guided and encouraged by your continued interest and comments.

PARKE, DAVIS & CO.

Research and Manufacturing Laboratories, Detroit 32, Michigan

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

Volume XXXIX MAY, 1953 No. 11

CONTENTS

SCIENTIFIC ARTICLES

Adams-Stokes Syndrome, Sidney Grau, M.D. 811
A Rational and Scientific Method for Evaluating Fluid and Electrolyte Therapy Postoperatively, John H. Kay, M.D., and Alton Ochsner, M.D. 815
A Review of the Effects of Various Drugs on Human Cerebral Circulation and Metabolism, Peritz Scheinberg, M.D. 817
Intramedullary Fixation of Fractures of Long Bones, John T. Ellis, M.D., and Samuel W. Windham, M.D. 820

ABSTRACTS OF MEDICAL ARTICLES

Drs. Sullivan G. Bedell, Roger E. Phillips, Arthur J. Butt, Carl S. McLemore, Samuel M. Day, F. Gordon King, James G. Lyerly, Chester Cassel, Thomas F. Nelson, Richard E. Strain, Ivan Isaacs, Raymond J. Fitzpatrick, Louis M. Orr, Barkley Beidleman, and Francis N. Cooke 831

EDITORIALS AND COMMENTARIES

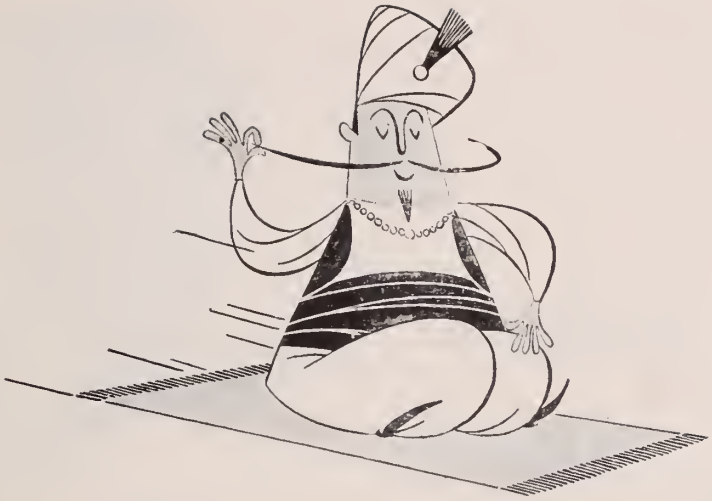
Pediatric Trends and Changing Concepts 838
Accident Toll in Children 839
All That Paper Work 839
A Woman's World? 840
Lecturers for Twenty-First Annual Graduate Short Course for Doctors of Medicine 840
Schedule for Short Course 841
Schedule for First Annual Meeting of the Florida Clinical Diabetes Association 842
Seminar on Gastroenterology 842
F.M.A. Exhibit at Orlando Fair 843
A.M.A. Annual Meeting, New York, June 1-5, 1953 844
Basic Policy for Gamma Globulin Distribution 844

GENERAL FEATURES

Officers and Committees 836
Births and Deaths 845
New Members 845
Medical Officers Returned 845
State News Items 846
Wanted — For Sale 848
Component Society Notes 850
Obituaries 853
Schedule of Meetings 861
List of County Societies, Presidents and Secretaries 862

This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida. October 23, 1924.



SMOOTH

diuresis

With suitably regulated doses, Thiomerin promotes gentle, sustained diuresis. Self-administration, under the physician's guidance*, is as practical as with insulin.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Thiomerin®

SODIUM

MERCAPTOMERIN SODIUM WYETH

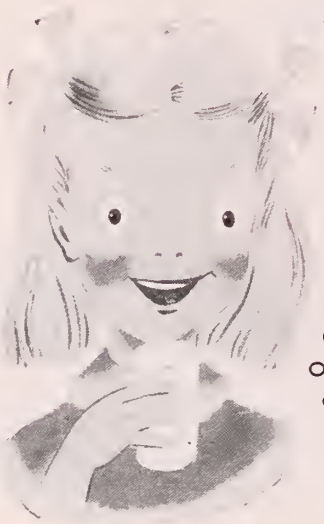
Council-Accepted Mercurial Diuretic for Subcutaneous, Intramuscular, or Intravenous Injection.

*A supply of printed instructions for patients will be sent to physicians on request.

Wyeth®
Philadelphia 2, Pa.

Children take it without the least bit of fuss...

SWALLOWED WHOLE



CHEWED— OR IN FOOD OR LIQUID

DISSOLVED ON TONGUE

- The Best Tasting Aspirin you Can Prescribe.
- The Flavor Remains Stable Down to the Last Toblet in the Bottle.
- 24 Tablet Bottle... 2½ gr. each 15¢

2½ gr. ◐ ⇨ ◑ 1¼ gr.

Grooved Tablets— Easily Halved

NEW FLAVORED

CHILDREN'S SIZE

BAYER ASPIRIN

We will be pleased to send samples on request

THE BAYER COMPANY DIVISION of Sterling Drug Inc., 1450 Broadway, New York 18, N.Y.

Upjohn

absorbable
hemostat:

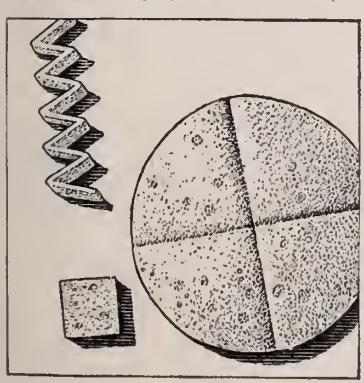
Available in a large variety of sizes and forms, including:
Surgical sponges
Compressed surgical sponges
Dental packs
Gynecologic packs
Nasal packs
Prostatectomy cones
Tumor diagnosis kit

Gelfoam

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Trademark Reg. U.S. Pat. Off. BRAND OF ABSORBABLE GELATIN SPONGE

The Upjohn Company, Kalamazoo, Michigan



Meat...

and the Low Sodium Diet

The beneficial effect of sodium restriction in the management of hypertension and many types of cardiac disease is firmly established. A low sodium diet aids in preventing edema and frequently leads to a significant reduction in arterial tension.

To emphasize the importance of sodium restriction and to enable the physician to present his patient with an informative discussion of the subject, The American Heart Association has just published a valuable pamphlet entitled "Food For Your Heart."* Covered also in this booklet is the importance of weight reduction in the management of the cardiac patient.

Dietary recommendations for three levels of sodium restriction are given. In all of them, meat is an important constituent of the diet. In the diet providing moderate sodium restriction (0.5 to 1.5 Gm. of sodium), 4 to 6 ounces of unsalted meat, fish or fowl are allowed. In severe restriction (0.5 Gm. sodium), 3 to 4 ounces of meat are permitted daily. The weight reduction-moderate sodium restriction diet calls for 5 to 6 ounces of meat daily.

This booklet again emphasizes the valuable application of meat in the dietary management of cardiac disease, hypertension, and obesity. Since, as the manual emphasizes, infectious diseases and such scourges as typhoid fever have now been controlled with antibiotics, chemotherapeutic agents and modern sanitation, "many physicians and scientists consider nutrition the most important environmental factor in health."

Meat, with its wealth of high quality protein, B complex vitamins and important minerals, plays an important role in the aim toward better national health. That the generous consumption of meat by the American people is a significant factor in attaining this goal is reflected in the statement that "most physicians feel that the high American consumption of protein is a good thing."

---

*Food for Your Heart, a Manual for Patient and Physician, Department of Nutrition, Harvard School of Public Health, Harvard University, The American Heart Association, Inc., New York, 1952. Copies available through local Heart Association.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute
Main Office, Chicago...Members Throughout the United States

cortisone + SCHERING = Cortogen

The symbol SCHERING denotes leadership in steroid hormone research and manufacture -- including Cortogen in the most useful clinical forms. For systemic therapy, use Cortogen tablets or injection . For eye disorders use Cortogen ophthalmic suspension -- sterile . The Schering seal appears on each tablet and package - your assurance of quality.

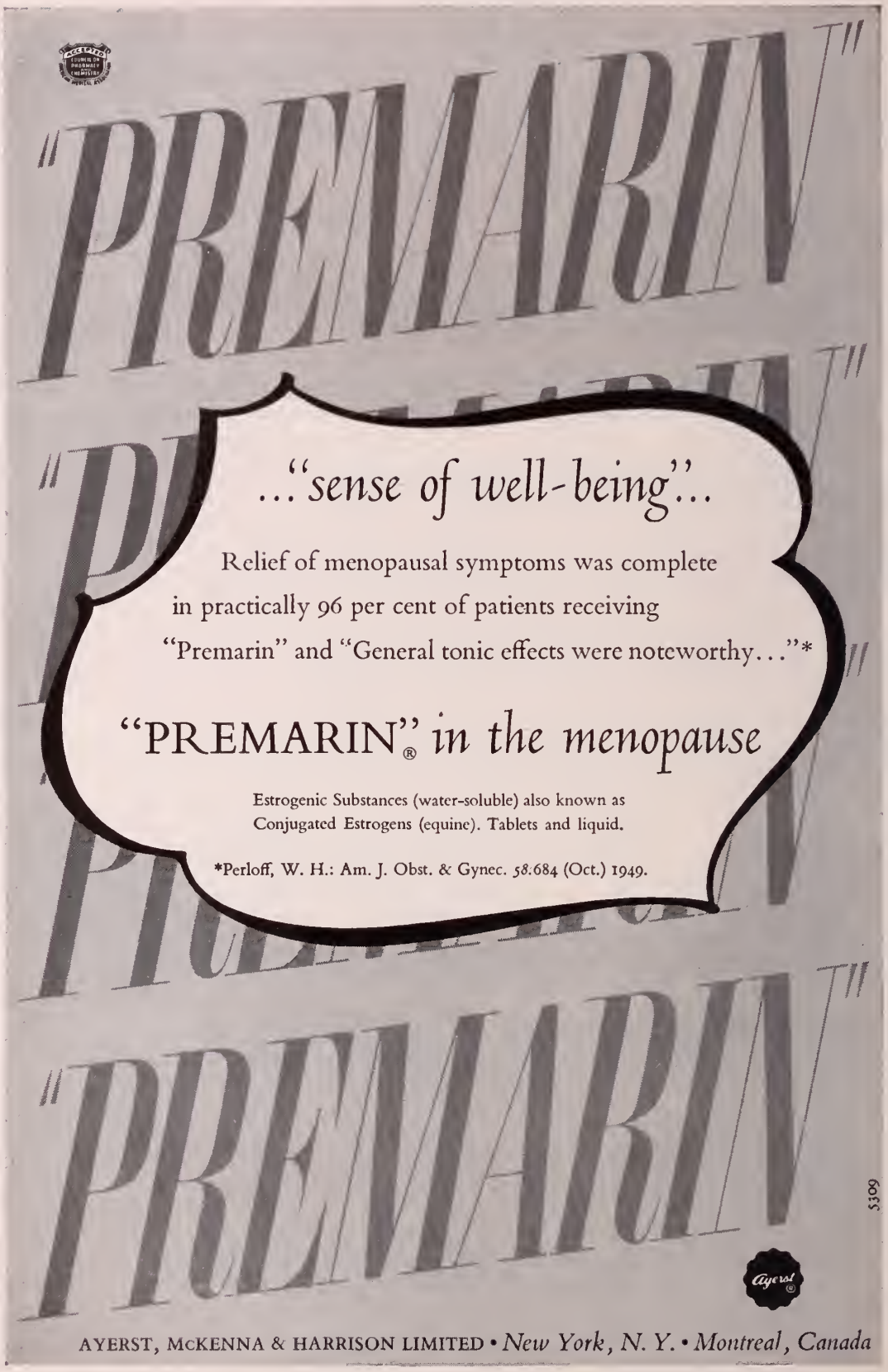
CORTOGEN®

Acetate (cortisone acetate, Schering) Tablets, 5 mg. and 25 mg.;
Injection, 25 mg. per cc., 10 cc. multiple-dose vials;
Ophthalmic Suspension—*Sterile*, 0.5% and 2.5%, 5 cc. dropper bottles.

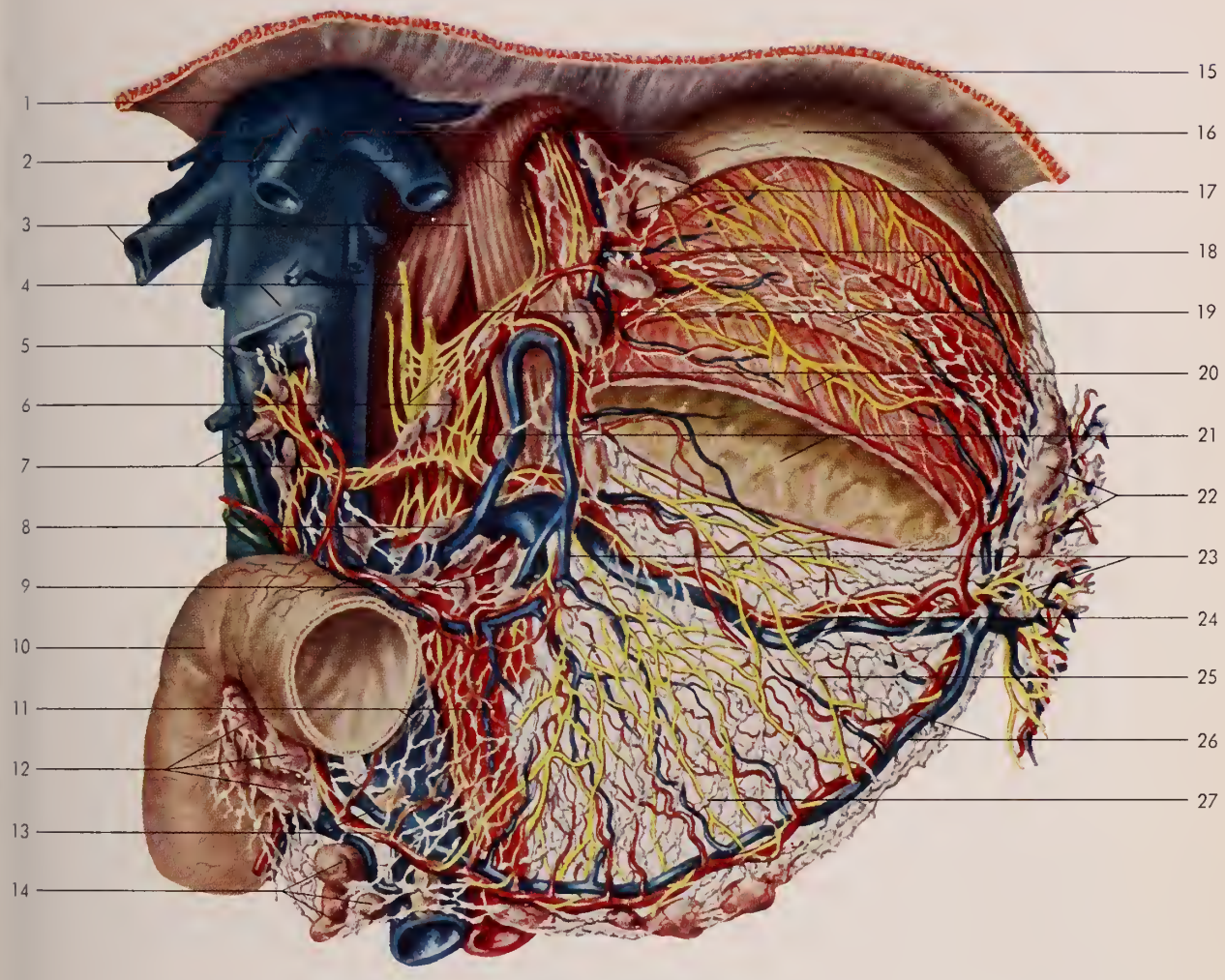
Schering CORPORATION · BLOOMFIELD, NEW JERSEY
In Canada: Schering Corporation, Ltd., Montreal.

CORTOGEN

SCHERING


"PREMARIN"
...."sense of well-being"....
Relief of menopausal symptoms was complete
in practically 96 per cent of patients receiving
"Premarin" and "General tonic effects were noteworthy..."*
"PREMARIN"® in the menopause
Estrogenic Substances (water-soluble) also known as
Conjugated Estrogens (equine). Tablets and liquid.
*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.
5309
Ayerst
AYERST, McKENNA & HARRISON LIMITED • New York, N. Y. • Montreal, Canada

Anatomy *of the* Stomach



1 Middle and left hepatic veins

2 Right vagus nerve and esophagus

3 Right hepatic vein and crura of diaphragm

4 Inferior vena cava and greater splanchnic nerve

5 Portal vein and hepatic artery

6 Celiac plexus and celiac artery

7 Hepatic lymph node and hepatic rami of vagus nerve

8 Gastroduodenal artery and suprapyloric lymph nodes

9 Superior gastric lymph nodes

10 Duodenum

11 Superior mesenteric artery and vein

12 Subpyloric lymph nodes

13 Right gastroepiploic artery and vein

14 Inferior gastric lymph nodes

15 Diaphragm

16 Serosa

17 Paracardial lymph nodes

18 Left vagus nerve and longitudinal muscular layer

19 Abdominal aorta and circular muscular layer

20 Left gastric artery and oblique muscular layer

21 Celiac rami of vagus nerve and gastric mucosa

22 Splenic lymph nodes

23 Left gastric (coronary) vein and splenic rami of vagus nerve

24 Splenic artery and vein

25 Gastric rami of vagus nerve

26 Left gastroepiploic artery and vein

27 Gastric lymphatic plexus

This is one of a series of paintings for Lederle by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.

Lederle

In perforated viscus,
in elective surgery of the stomach,
as well as for
gastroenteric infections–

Aureomycin

HYDROCHLORIDE CRYSTALLINE

often acts promptly to prevent
or control infection in all
the tissues and body fluids

Literature available on request–

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.

Mobilizing Fluid

IN CARDIAC EDEMA

"Mercurial diuretics are a most effective means of mobilizing fluid in patients with cardiac edema. The use of these agents may augment greatly the effect of sodium restriction and digitalis administration."[1]

Salyrgan-Theophylline — a combination of a potent mercurial diuretic with theophylline — is effective orally in certain cases as well as parenterally. It is extensively used in the treatment of cardiac and cardiorenal edema, dropsy of nephrosis, and ascites of hepatic cirrhosis.

1. Thorn, G. W., and Tyler, F. H.: *Med. Clin. North America*, 31:1081, Sept. 1947.

Salyrgan, trademark reg. U. S. & Canada

Salyrgan®-
THEOPHYLLINE
BRAND OF MERSALYL AND THEOPHYLLINE
Ampuls (1 and 2 cc.)—Ampins (1 cc.)—Tablets

Winthrop-Stearns INC.
New York 18, N. Y. Windsor, Ont.

"No! Worse than that! He forgot to call the MEDICAL SUPPLY MAN!"

And that *can* be serious — especially if an emergency calls for the use of some "out-of-order" equipment. The best thing to do is to call the Medical Supply Man the minute something goes wrong. He'll put stubborn equipment back in good order in jig time.

In fact, it's a good idea to call the Medical Supply Man anytime you need help. Ordinarily, we carry more than 15,000 individual items in stock at all times and do our very best to furnish you with the supplies and equipment you need — fast!

So, don't take chances on being caught unprepared. For supplies, service or equipment, and fast, dependable service CALL THE MEDICAL SUPPLY MAN.

HOSPITAL, PHYSICIANS and LABORATORY SUPPLIES & EQUIPMENT

MEDICAL SUPPLY COMPANY

Essentials For Scientific Progress

MIAMI • of JACKSONVILLE • ORLANDO

230 N. E. THIRD ST
MIAMI 32, FLA

420 WEST MONROE ST.
JACKSONVILLE 2, FLA.

329 N. ORANGE AVE.
ORLANDO, FLA.

IN SPRING ALLERGIES . . .

Allay Distress

Patients suffering from Spring allergies can be relieved promptly of annoying symptoms—with NEO-ANTERGAN.

NEO-ANTERGAN effectively blocks the tissue histamine receptors, affording quick comfort with a minimum of sedation or other undesirable effects.

Promoted exclusively to the profession, NEO-ANTERGAN is available only on your prescription.

Your local pharmacy stocks NEO-ANTERGAN Maleate in 25 and 50 mg. coated tablets in bottles of 100, 500, and 1,000.

The Physician's Product

Neo-Antergan®

MALEATE

(PYRILAMINE MALEATE, MERCK)

COUNCIL ACCEPTED

Research and Production for the Nation's Health

MERCK & CO., INC.

Manufacturing Chemists

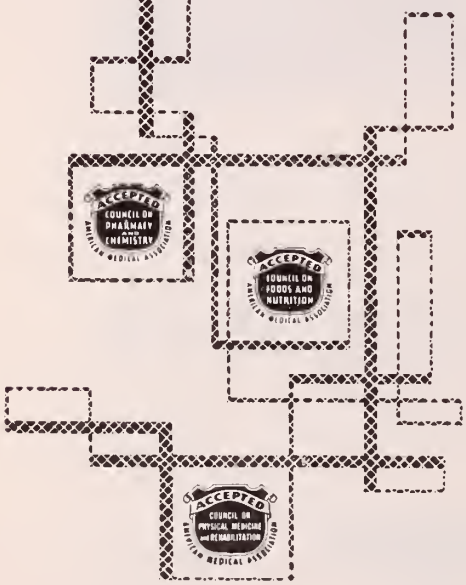
RAHWAY, NEW JERSEY

It is

PRICELESS

yet, FREE

YES, the A. M. A. Council Seal is awarded without payment of any fee or obligation to advertise.



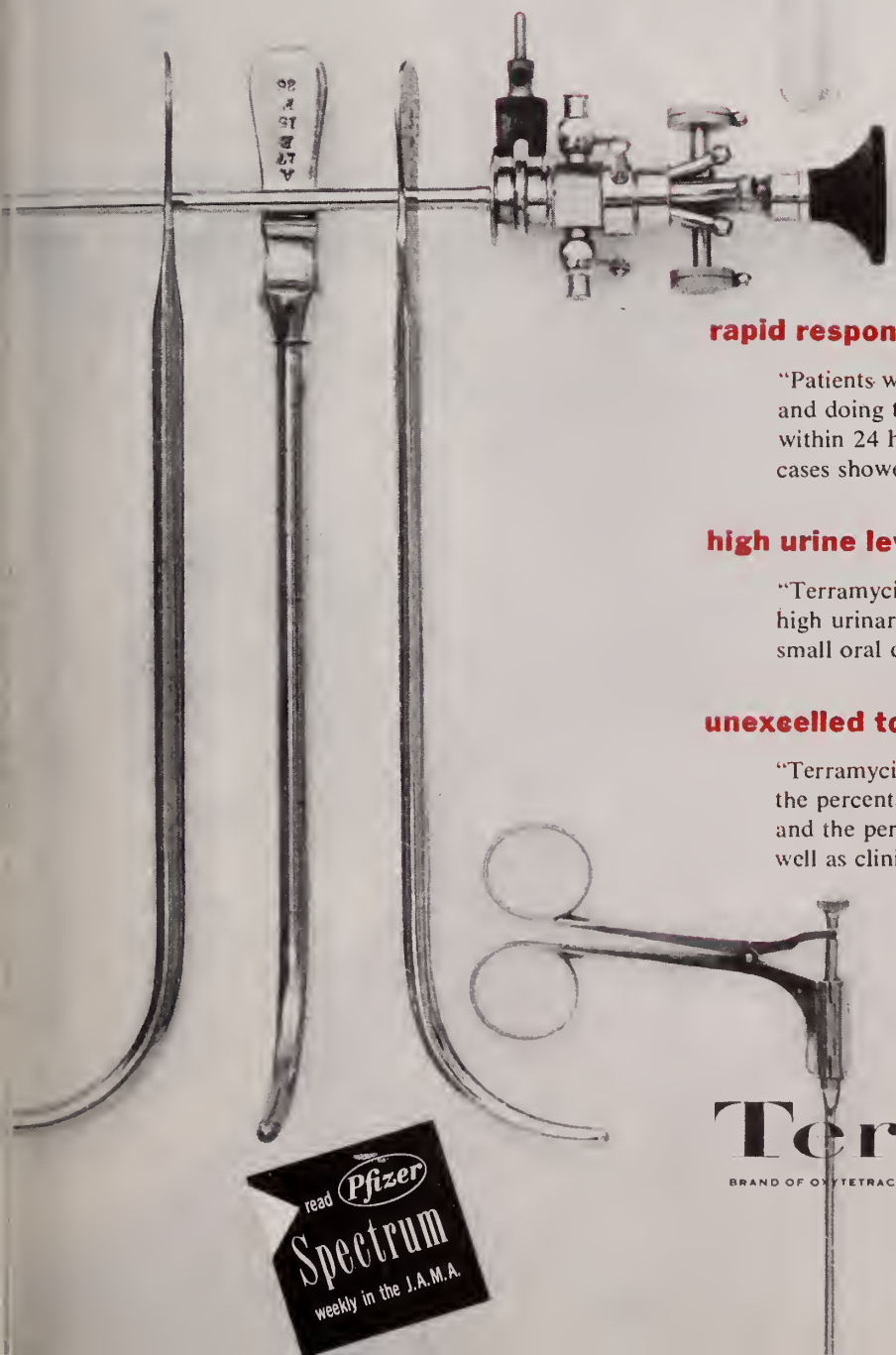
The manufacturers submit their products on a purely voluntary ba
The evidence is reviewed—the claims are checked—the chemi
laboratory makes the necessary tests and the results are examined b
critical group of physicians in various fields of medicine.

If the product is found satisfactory and necessary conditions are m
it is awarded Council Acceptance. This intensive examination by
Council is made without fee from the manufacturer—there is no p
ment of any sort made. The Council's actions are based on purely
available evidence—not any financial consideration.

If anyone tells you "they cannot afford Council Acceptance for th
product," you can discount it 100%—the chances are that member
his firm are not familiar with Council Rules or Standards, or did
realize that the product could be acceptable to the Council.

This is one of a series of advertisements designed to explain the Councils' functions to you.

IN URINARY TRACT INFECTIONS



rapid response

"Patients with pyelitis were well and doing their usual duties within 24 hours . . ."[1] ". . . resistant cases showed remarkable response."[2]

high urine levels

"Terramycin was selected . . . in view of high urinary excretion rate following small oral doses of the antibiotic."[1]

unexcelled toleration

"Terramycin is generally well tolerated, the percentage of relapses being low and the percentage of bacteriological as well as clinical cures high."[3]

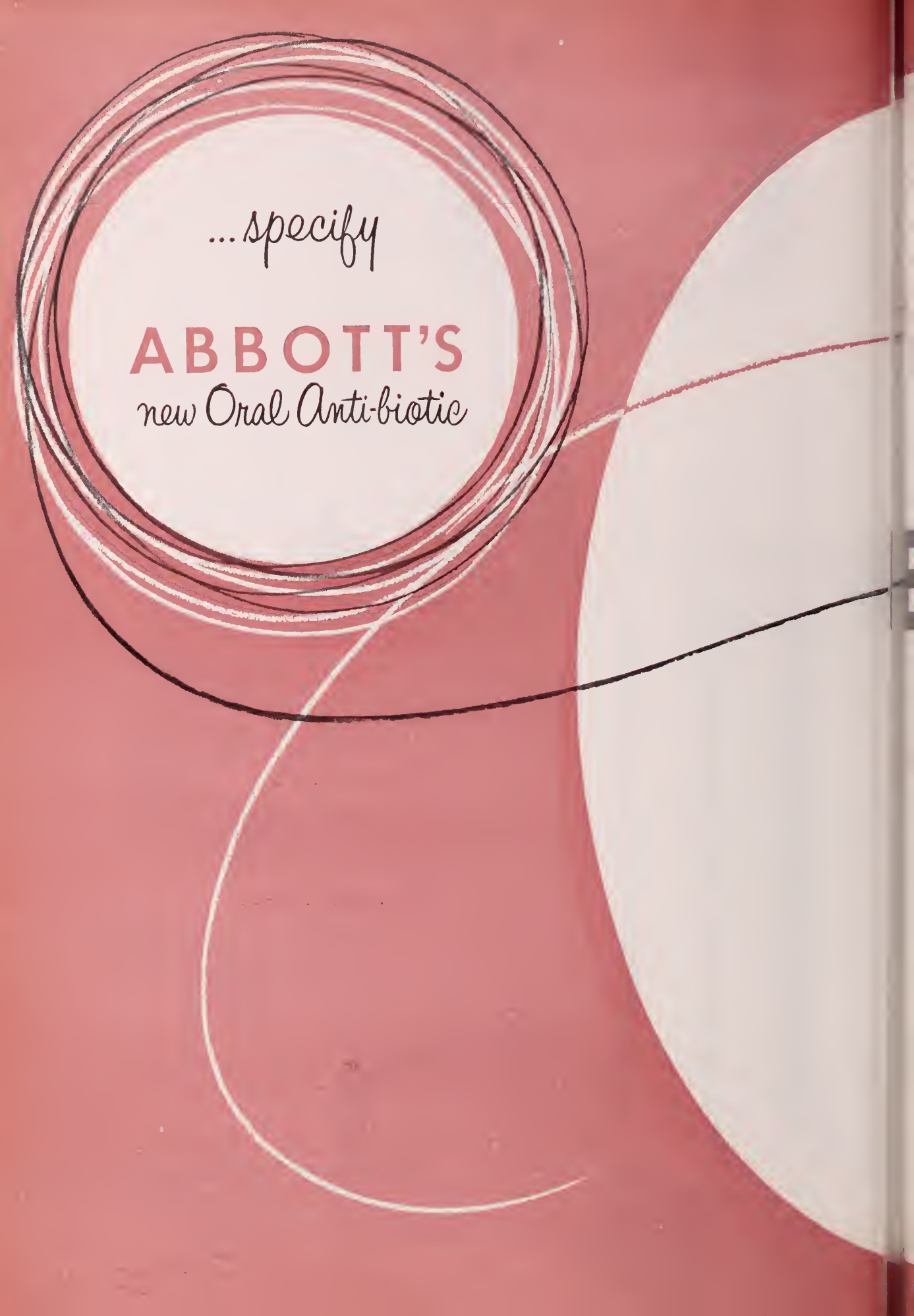
1. Canad. M. A. J. 66:151 (Feb.) 1952.
2. J. Urol. 67:762 (May) 1952.
3. Ibid. 69:315 (Feb.) 1953.

Terramycin

BRAND OF OXYTETRACYCLINE

Pfizer

read Pfizer Spectrum weekly in the J.A.M.A.


...specify
ABBOTT'S
new Oral Anti-biotic

Especially effective against gram-positive organisms resistant to other antibiotics.

Low toxicity; reported side effects infrequent.

Special "high-blood-level" coating.
ERYTHROCIN, *0.1-Gm. (100-mg.) Tablets, bottle of 25.*

ERYTHROCIN

TRADE MARK

(Erythromycin, Abbott)

INDICATIONS Pharyngitis, tonsillitis, scarlet fever, erysipelas, pneumococcic pneumonia, osteomyelitis, pyoderma. *Also other infections caused by organisms* susceptible to its action, including staphylococci, streptococci and pneumococci.

DOSAGE Total daily dose of 0.8 to 2 Gm., depending on severity of the infection. A total daily dose of 0.6 Gm. is often adequate in the treatment of pneumococcic pneumonia. *For the average adult* the initial dose is 0.2 Gm. to be followed by doses of 0.1 or 0.2 Gm. followed by doses in the same range every four to six hours. *For severely ill patients* doses up to 0.5 Gm. may be repeated at six-hour intervals if necessary. Satisfactory clinical response should appear in 24 to 48 hours if the causative organism is susceptible to ERYTHROCIN. Continue for 48 hours after temperature returns to normal. Abbott

1. McGuire et al. (1952), J. Antibiotics & Chemo., 2:281, June.
2. Heilman et al. (1952), Proc. Staff Meet. Mayo Clin., 27:385, July 16.
3. Haight and Finland (1952), New Eng. J. Med., 247:227, Aug. 14.

PROOF WITH ONE PUFF?

So distinct is the difference between PHILIP MORRIS and *any* other leading brand, that we believe you will notice it with a single puff. Won't you try this simple test, Doctor, and see?

Take a PHILIP MORRIS and any other cigarette

1. Light up either one first. Take a puff—get a good mouthful of smoke—and s-l-o-w-l-y let the smoke come directly through your nose.
2. Now, do exactly the same thing with the other cigarette.

You will notice a distinct difference between PHILIP MORRIS and any other leading brand.

PHILIP MORRIS

Philip Morris & Co., Ltd., Inc., 100 Park Avenue, New York 17, N. Y.

For every age group...

this

Broad Spectrum

DIETARY SUPPLEMENT

Regardless of cause or patient age, the need for dietary supplementation frequently arises. Whenever such supplementation is indicated to round out the intake of essential nutrients, a truly broad spectrum supplement—one that supplies notable amounts of all important nutrients—will serve the patient optimally.

Ovaltine in milk, a delicious food drink, has long been widely prescribed for this purpose. As the appended table shows, it supplies substantial amounts of virtually all nutrients known to take part in metabolism, from biologically top-grade proteins, through the gamut of the essential vitamins, to the minerals needed in trace amounts.

Whenever the patient's nutritional state must be improved, Ovaltine deserves the physician's first consideration.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three Servings of Ovaltine in Milk Recommended far Daily Use Pravide the Follawing Amaunts of Nutrients

(Each serving made of ½ oz. af Ovaltine and 8 fl. az. af whale milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.15 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete) 32 Gm.
*CARBOHYDRATE 65 Gm.
*LIPIDS 30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council

VOLUME XXXIX
NUMBER 11

Announcing a scientifically in cigarette smoking...

KENT with the exclusive "MICRONITE" FILTER

DOCTORS have long been aware of the need for a really effective filter-tipped cigarette. P. Lorillard Company has been conscious of this problem, and after years of study, experiment and research believes it has developed a cigarette that meets the need.

It is the new KENT cigarette with the "Micronite"* Filter. Recent tests have shown that the Micronite Filter *approaches 7 times the efficiency of other filters in the removal of tars and nicotine* and is virtually twice as effective as the next most efficient cigarette.

All members of the medical profession will be interested in the facts about this new cigarette. To avoid possible confusion or misunderstanding by the general public, the details of the KENT studies given on these pages are for physicians only and will not appear in KENT advertising or promotion to the general public.

Micronite as a cigarette filter...

The new filter material—called Micronite—stems directly from the improved protective filters developed to meet critical air-purification problems in atomic energy plants.

When investigations showed that this filter medium was capable of removing all of the minute particles from a stream of cigarette smoke, the filter was modified for use in KENT cigarettes. *This was done in such a way as to permit the passage of pleasant aromatic smoke constituents, but with a removal of the more objectionable fractions of tobacco smoke to an extent never before accomplished.*

Efficacy of the Micronite Filter

The normal human subjects used in testing the Micronite Filter were divided into two categories—*susceptible and non-susceptible*—on the basis of their subjective reactions to cigarette smoking. Approximately two-thirds of the subjects *in this investigation* were *non-susceptible* while the remaining third were definitely *susceptible*. Other investigations have reported a somewhat similar ratio. (a)

To study the effects of this filter on physiological reactions to cigarette smoke, in both *susceptible and non-susceptible persons*, two different tests were employed, both being measurements of peripheral blood flow.

The first test involves the drop in skin temperature occurring at the finger tip, induced by smoking and measured according to *well-established procedures*. (b, c)

The second test is a measurement of vasoconstriction in the hand, as recorded plethysmographically. (d)

The results of these measurements—determined for Lorillard by an independent research organization—are shown on the four charts reproduced here. Concurrently, other outside independent laboratories are carrying on further research on the chemical and physiological effects of cigarette smoking *with new and original testing methods.*

From these charts, the following general conclusions may be drawn:

When cigarette smoke is drawn through a Micronite Filter, it is no longer capable of producing characteristic changes in peripheral blood flow in either *susceptible or non-susceptible persons.*

The Micronite Filter is vastly superior to *any other available filter now in use* for removing tars and nicotine in cigarette smoke.

*PATENT APPLIED FOR

PHYSICIANS:

Today, KENTs are sold in most major U. S. cities. If your city is not yet among them, simply write to P. Lorillard Company, 119 West 40th Street, New York, N. Y., and special arrangements will be made to assure you of a regular supply.

significant development

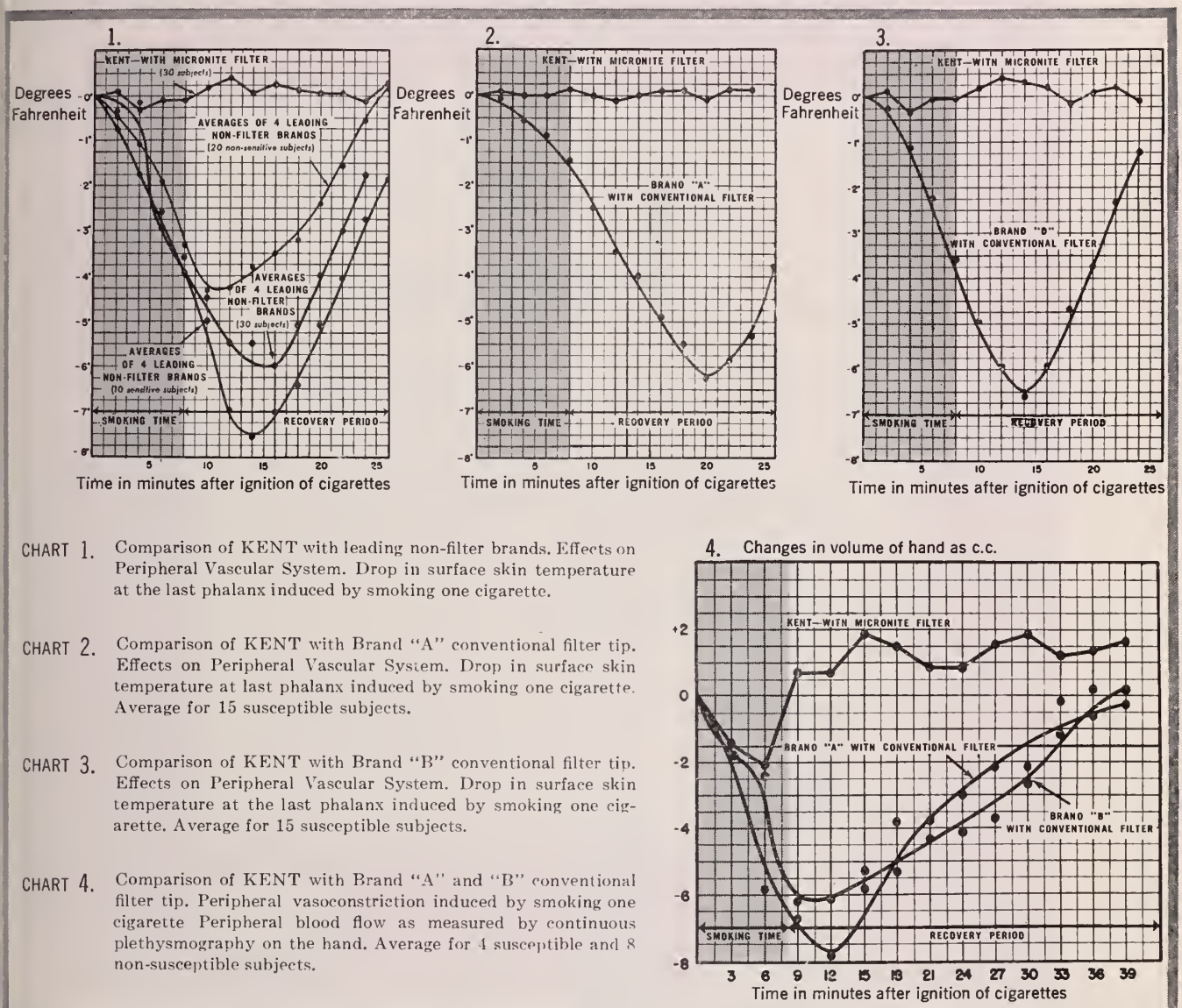


CHART 1. Comparison of KENT with leading non-filter brands. Effects on Peripheral Vascular System. Drop in surface skin temperature at the last phalanx induced by smoking one cigarette.

CHART 2. Comparison of KENT with Brand "A" conventional filter tip. Effects on Peripheral Vascular System. Drop in surface skin temperature at last phalanx induced by smoking one cigarette. Average for 15 susceptible subjects.

CHART 3. Comparison of KENT with Brand "B" conventional filter tip. Effects on Peripheral Vascular System. Drop in surface skin temperature at the last phalanx induced by smoking one cigarette. Average for 15 susceptible subjects.

CHART 4. Comparison of KENT with Brand "A" and "B" conventional filter tip. Peripheral vasoconstriction induced by smoking one cigarette Peripheral blood flow as measured by continuous plethysmography on the hand. Average for 4 susceptible and 8 non-susceptible subjects.

Here are additional observations from work now in progress:

1. When smoke which has passed through a Micronite Filter contacts the conjunctival sac of the rabbit, far less irritation occurs than when the sac is exposed to the smoke from regular cigarettes or the smoke from popular filter-tipped brands.

2. Current studies also indicate that Micronite-filtered smoke is less irritating to mucous membranes than unfiltered smoke.

When the scientific evidence of the effectiveness of the Micronite Filter is compared *with* the effectiveness of other filters, *it shows that*—

The problem of smoker susceptibility to tobacco irritants may be largely overcome by KENTs. And for those people whose smoking should be restricted for therapeutic reasons, *KENTs should be considered* as the cigarette of choice.

P. Lorillard Company will gladly send you a booklet, prepared especially for the medical profession, which describes more fully the investigational work on the chemical and physiological advantages of the new Micronite-filtered KENT cigarette.

References Cited

a. *A Manual of Pharmacology*, 7th Edition, Philadelphia. W. B. Saunders Co., 1949, pp. 341-352.
b. *J.A.M.A.*, Vol. 103, 1934, p. 318.
c. *J.A.M.A.*, Vol. 135, 1947, p. 417.
d. *J.A.M.A.*, Vol. 104, 1935, p. 1963.

1 *Reason for the Continuing Decline in Maternal Morbidity and Mortality . . .*

Eli Lilly and Company
Indianapolis 6, Indiana, U.S.A.

Lilly

For sustained contraction of the postpartum uterus

AMPOULES AND TABLETS

Ergotrate Maleate

(ERGONOVINE MALEATE, U.S.P., LILLY)

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXIX Jacksonville, Florida, May, 1953 No. 11

Adams-Stokes Syndrome

Sidney Grau, M.D.
ST. PETERSBURG

The treatment and subsequent management of a patient exhibiting syncopal attacks with partial or complete auriculoventricular block continues to be a distressing therapeutic problem. The symptom complex which now bears their names was first described by Adams in 1827[1] and by Stokes in 1846.[2] In the past the basic cardiac mechanism responsible for the symptoms has been considered to be ventricular standstill. More recent investigation, especially during the past 10 years, has shown that Adams-Stokes syndrome may be caused not only by ventricular asystole, but also by ventricular tachycardia or transient ventricular fibrillation. Electrocardiograms taken during a syncopal attack have been published[3,4] verifying this contention. In a recent report on the subject, Pastor and Worrilow[5] published a case illustrating electrocardiographically the various mechanism that may occur.

The following 2 cases, observed during the past year, are further examples of Adams-Stokes syndrome.

Report of Cases

Case 1.—C. W., a 52 year old white English machine operator, was first seen on May 3, 1952 because of "black out spells." A history was obtained of angina pectoris, occurring intermittently since 1943, easily relieved by nitroglycerin. The patient had never been incapacitated because of the pain, had worked at his trade constantly during the past 10 years and had recently arrived in the United States with the hope of becoming a citizen. On April 23, 1952, while working, he suddenly became dizzy, perspired profusely and then fainted. He was revived shortly and sent home. On April 28, while at home, he had five similar episodes occurring within 45 minutes. The attacks were not preceded by any premonitory symptoms; they were sudden in onset, and the patient would wake up spontaneously. He hardly ever wore tight collars, nor could he recall the attacks being brought on by sudden movements of the head. He recalled that in March 1952, while fishing, he fell off a retaining sea wall for no apparent reason and had to be pulled out of the water. He stated he was embarrassed at the time by the incident for everyone thought he was drunk. Systemic review otherwise gave negative results with the exception of an 8 pound loss in weight during the preceding six months.

Physical examination revealed a well developed, moderately obese white man, appearing well. The weight was 165 pounds. The blood pressure was 176 systolic and 100 diastolic. The pulse rate was 62 and regular. Significant physical findings were limited to the cardiovascular system. The left border of the heart was 12 cm. from the midsternal line in the fifth interspace. No retrosternal dulness was present. A rough grade II systolic murmur was heard over the aortic area with transmission to the neck. This murmur was heard best during forced expiration with the patient in the upright position. No other murmurs were elicited. There were no thrills. Peripheral pulsations were normal. There was no evidence of congestive failure.

An electrocardiogram (fig. 1) showed a prolonged P-R interval (0.22 sec.) and a widened QRS (0.13 sec.). The interpretation was normal sinus rhythm, first degree auriculoventricular block, right bundle branch block and definitely abnormal curve. Fluoroscopic examination of the chest revealed enlargement of the outflow tract of the left ventricle plus widening and elongation of the thoracic aorta.

Clinical Course: The patient was fully advised as to his physical condition. He was given ¾ grain of ephedrine sulfate four times daily and advised not to return to work for the time being. On May 8, while shaving, he suddenly "blacked out," fell and cut his chin, the wound requiring four sutures. Three days later there developed dull, persistent substernal pain which was not relieved by nitroglycerin. He was admitted to a local hospital on May 12. An electrocardiogram at this time showed a second degree auriculoventricular block with a ventricular rate of 36. Changes in the electrocardiogram from the preceding one were indicative of a recent infarction of the posterior wall. The substernal pain was rapidly relieved, and there was no recurrence. In addition to the routine management for an acute coronary occlusion, the patient continued to receive ¾ grain of ephedrine sulfate four times daily, plus 1 cc. of adrenalin in oil (1/500 dilution) intramuscularly every six hours. During his hospital stay the pulse rate varied from 30 to 48, he had no syncopal attacks, and recovery was uneventful. He was checked routinely on June 16 in the office, at which time an electrocardiogram (fig. 2) showed a complete auriculoventricular block with an idioventricular rhythm of 28. He was given maintenance therapy of ¾ grain of ephedrine sulfate every three hours, and allowed little activity. On June 34, while eating breakfast, he suddenly slumped forward and expired. Permission for autopsy was not obtained.

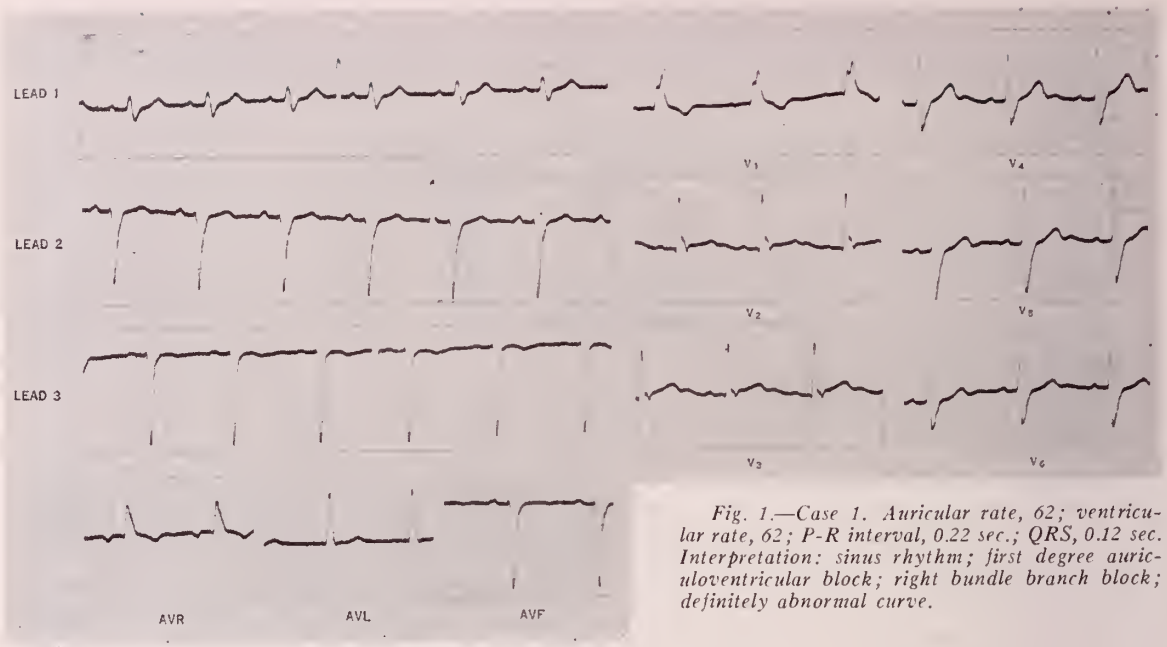


Fig. 1.—Case 1. Auricular rate, 62; ventricular rate, 62; P-R interval, 0.22 sec.; QRS, 0.12 sec. Interpretation: sinus rhythm; first degree auriculoventricular block; right bundle branch block; definitely abnormal curve.

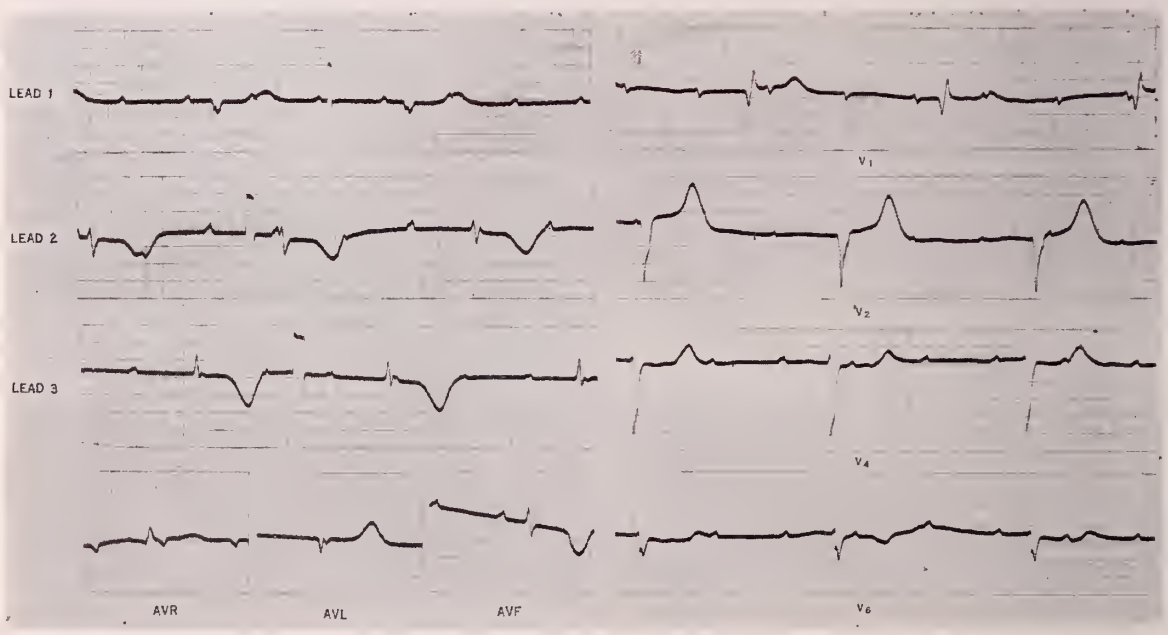


Fig. 2.—Case 1. Auricular rate, 77; idioventricular rate, 28; QRS, 0.12 sec. Interpretation: sinus rhythm; complete auriculoventricular block with the idioventricular pacemaker probably arising above the bifurcation of the common auriculoventricular bundle; shows a healing posteroseptal wall infarction; definitely abnormal curve.

Case 2.—C. O., a 64 year old white man, was first seen on May 24, 1952 in the emergency room of a local hospital as an apparent drowning victim. He had been found by friends floating face down in shallow water where he seemingly was all right just a few moments before. A friend who accompanied the patient to the hospital stated that he had "blacked out" three months previously and had been informed by a doctor at that time that he had a "bad heart."

Physical examination revealed the patient to be in extremis; breathing was rapid and shallow, pulse rate 18 and presumably regular, and blood pressure 70/?. There was pronounced cyanosis of the face and lower extremities. The eyegrounds were not remarkable; nuchal rigidity was absent; deep reflexes were hypoactive throughout, and there were no pathologic reflexes. The breath sounds were noisy with bubbling rhonchi and rales heard throughout both lung fields. These sounds prevented proper auscultation of the heart.

Clinical Course: Emergency therapy was instituted consisting of bronchial aspiration and oxygen by nasal catheter. The color improved immediately, the pulse rate rose to 30 per minute and the blood pressure to 100 systolic and 50 diastolic. Because of the previous "black out" spell and the rapidity of onset of the present episode plus the slow ventricular rate, it was concluded that this was another instance of Adams-Stokes syndrome. The patient was therefore given ½ cc. of aqueous adrenalin (1/1000 dilution) followed by 1 cc. of adrenalin in oil (1/500 dilution) intramuscularly. On the following morning the pulse rate was 36 and regular; the temperature was 101 F. orally.

On physical examination, there was evidence of consolidation of the lower lobe of the left lung, which was substantiated by portable x-ray examination. An electrocardiogram showed a second degree auriculoventricular block, conduction varying from 2:1 to 3:1 with the Wenckebach phenomenon; and right bundle branch block, but no evidence of recent myocardial infarction. The blood count was red blood cells 5.0 million, hemoglobin 98 per cent, and white blood cells 18,300 with 92 per cent polymorphonuclears. Urinalysis gave negative results. The blood urea nitrogen was 20.5 mg. per hundred cubic centimeters and the carbon dioxide 18.7 milliequivalents. He was given terramycin, 500 mg. every four hours. The temperature fluctuated between 101 and 103 F. for the next four days and then gradually returned to normal in the ensuing week. The physical findings of involvement of the lower lobe of the left lung also gradually disappeared. A repeat electrocardiogram, taken on May 28 (fig. 3), showed no significant change from the preceding electrocardiogram except that the Wenckebach phenomenon was no longer present. The pulse rate varied from 18 to 45 throughout the hospital stay. There were no syncopal attacks.

The patient was discharged on June 6, fully advised of his physical status. He was given maintenance therapy of ¾ grain of ephedrine sulfate five times daily. His male companion was instructed as to the use of aqueous adrenalin in case of future attacks of syncope. One such attack has occurred since discharge from the hospital. He awoke spontaneously within 30 seconds. When last heard from he was feeling well and had had no further recurrence.

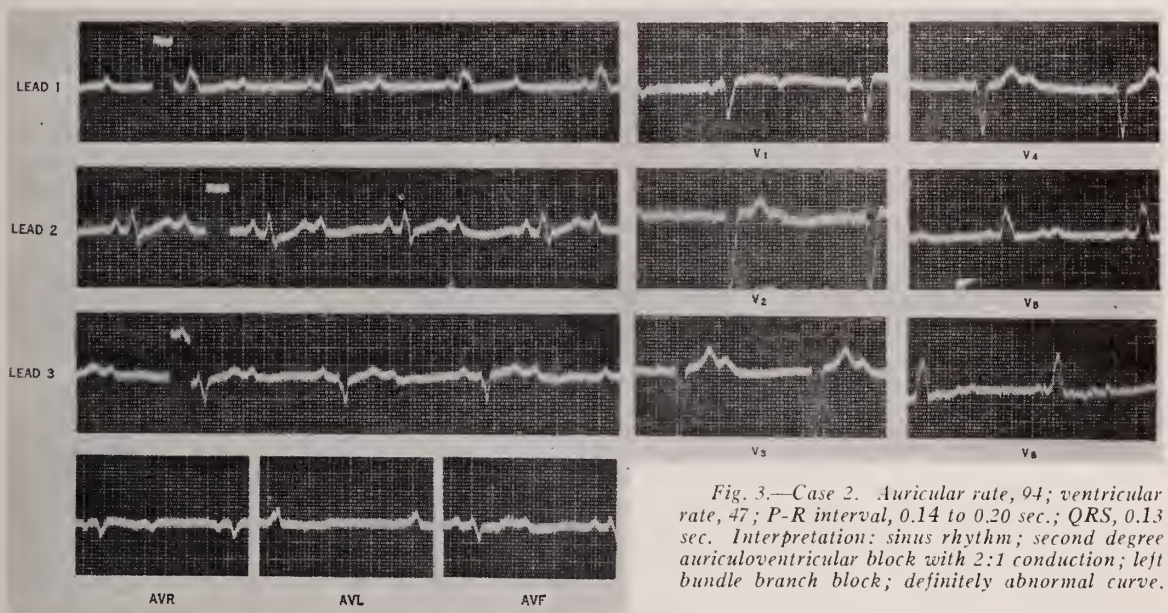


Fig. 3.—Case 2. Auricular rate, 94; ventricular rate, 47; P-R interval, 0.14 to 0.20 sec.; QRS, 0.13 sec. Interpretation: sinus rhythm; second degree auriculoventricular block with 2:1 conduction; left bundle branch block; definitely abnormal curve.

Discussion

Because of the various possibilities that might exist contributing to an Adams-Stokes syndrome, every attempt should be made to ascertain the underlying cardiac mechanism before therapy is instituted. It must be realized that different mechanisms may be present during the same syncopal attack; for example, ventricular asystole may alternate with ventricular tachycardia or even transient ventricular fibrillation. When this mechanism occurs, it is difficult to decide which course of therapy to pursue. If time permits and the facilities are at hand, an immediate electrocardiogram should be taken in order to determine the arrhythmia responsible for the attack. The stethoscope may not be of benefit during an attack since ventricular asystole cannot be differentiated from ventricular fibrillation by auscultation alone.

In cases exhibiting ventricular asystole or complete auriculoventricular block with a slow ventricular rate, the drug of choice appears to be aqueous adrenalin administered either parenterally or via the intracardiac route, depending on the urgency of the case. Adrenalin in oil or ephedrine sulfate has been advocated as maintenance therapy to prevent further attacks. In the second case described, this method of control so far has appeared to be of value. In the presence of ventricular tachycardia the use of parenteral or intracardiac adrenalin may be fraught with danger.

When it has been shown that the basic mechanism resulting in an attack is ventricular tachycardia, the consensus is that quinidine is the drug of choice. The advisability of using quinidine has been seriously questioned by some investigators because of its pharmacologic actions. Quinidine may increase both intraventricular block and auriculoventricular block, and the resultant harm done to the patient may overshadow the immediate benefits. Quinidine, therefore, should be used cautiously in patients with Adams-Stokes syndrome exhibiting ventricular tachycardia. Its administration should be followed with frequent electrocardiograms. More recently, procaine amide hydrochloride (pronestyl(R)) has been advocated for the treatment of ventricular tachycardia. No reference could be found in the literature as to its use in patients with Adams-Stokes syndrome. It can be stated categorically, however, that procaine amide hydrochloride, like quinidine, may precipitate ectopic ventricular rhythms as well as depressing auriculoventricular and intraventricular conduction. Its use, therefore, should also be followed with electrocardiograms and the drug discontinued if evidence appears of progressive prolongation of the P-R interval or excessive widening of the QRS complex.

When ventricular fibrillation is established as the cause of Adams-Stokes attacks, the prognosis is most grave. Ventricular fibrillation is, with few exceptions, an irreversible condition resulting in death. At times it may be transient, but even in this form it is ominous. Most patients showing this type of arrhythmia will be dead within a year from the onset. It has been stated[6] that probably as many people die from ventricular fibrillation as from ventricular asystole and that the former condition is one of the more common causes of death in patients with disease of the coronary arteries.

Ventricular fibrillation is recognized electrocardiographically by the absence of QRS complexes and the occurrence of irregular oscillations, both in amplitude and contour. As in ventricular tachycardia, the drug of choicé is quinidine, but here also the rationale in using this drug has been questioned. It has been postulated that in some cases quinidine has initiated ventricular fibrillation or if the fibrillation was already present, has perpetuated it by depressing conduction and thus maintaining the ventricular circus movement.

Possibly the best treatment for ventricular fibrillation is its prevention. With the use of the precautionary measures outlined, quinidine in prophylactic doses has proved to be of some value. Barium chloride has also been mentioned as a prophylactic measure, but has not been proved to be efficacious. As with quinidine, it is believed that barium chloride may, at times, initiate ventricular fibrillation, and it has even been used experimentally for this purpose.[7]

Conclusion

Two cases of Adams-Stokes syndrome which were recently observed have been reported. A brief review of the underlying cardiac arrhythmias responsible for this condition is presented as well as the treatment indicated for each arrhythmia.

References

1. Adams, R.: Cases of Disease of the Heart Accompanied with Pathological Observations, Dublin Hospital Rep. 4:396, 1827.
2. Stokes, W.: Observations on Some Cases of Permanently Slow Pulse, Dublin Quart. J. M. Sc. 2:73, 1846.
3. Parkinson, J.; Papp, C., and Evans, W.: Electrocardiogram of Stokes-Adams Attack, Brit. Heart J. 3:171-199 (July) 1941.
4. Levine, S. A., and Matton, M.: Adams-Stokes Syndrome, Showing Ventricular Fibrillation and Asystole Lasting Five Minutes, with Recovery Following Intracardiac Injection of Adrenalin, Heart 12:271-279 (March) 1926.
5. Pastor, B. H., and Worrilow, S. H.: Electrocardiographic Patterns in Stokes-Adams Syndrome, Ann. Int. Med. 34:80-89 (Jan.) 1951.
6. Katz, L. N.: Electrocardiography Including an Atlas of Electrocardiograms, ed. 2, Philadelphia, Lea & Febiger, 1946, p. 700.
7. Blumenthal, B., and Oppenheimer, E. T.: Method for Study of Ventricular Fibrillation, Am. Heart J. 18:363-367 (Sept.) 1939.

705 Times Building.

Index to Volume XXXIX

to be Published

in June Issue

A Rational and Scientific Method for Evaluating Fluid And Electrolyte Therapy Postoperatively

John H. Kay, M.D.*
PANAMA CITY
AND
Alton Ochsner, M.D.
NEW ORLEANS

In view of the controversy over what procedure should be used to determine the requirements for water and specific electrolytes postoperatively, the postoperative metabolism of electrolytes was studied by the use of radioactive potassium, sodium, and phosphorus. In addition, chemical determinations of the blood levels and urinary excretion of chloride were also made. The patients used were selected from the surgical wards at random, and the procedures varied from biopsy of the breast to a resection of the head of the pancreas.

In general, the radioactive substance was given shortly before the operative procedure was begun, and its urinary excretion and blood level were followed, measurements being made at frequent intervals during the operative procedure and at somewhat longer intervals after the patient had been returned to the ward. In one case, the patient was taken to the operating room, and the usual procedures which precede anesthesia were performed without anesthesia being given and without the patient being operated upon. Excretion levels were followed in this patient in the same manner.

In was of great interest to us that the calculated figures for excretion of potassium, sodium, phosphorus and chloride showed that a relative renal shutdown occurred after all the procedures that we studied. In general, the length of time that the kidney remained shut down was proportional to the size of the operation. In the lesser procedures, the renal shutdown lasted for a matter of one to two hours. In the patient in whom no operation was performed, a similar renal shutdown occurred, but it lasted for only approximately 30 minutes.

*Presently at Adams Hospital, Panama City.
From the Department of Surgery, Tulane University of Louisiana School of Medicine, New Orleans.

It was of equal importance to note that the amount of water excreted in the unit time during this period of shutdown was relatively constant at about 0.4 to 0.6 cc. per minute or 24 to 36 cc. per hour and that when the electrolytes began to be excreted in higher concentration, the amount of water excreted also increased. Thus it may be said that during this period blood levels of the electrolytes varied while the amounts excreted in the urine became relatively fixed in relation to the amount of water excreted. When these values are expressed in terms of output per minute, the curves of excretion of electrolytes and water during the period of renal shutdown vary proportionately; and as the shutdown period begins to end, the amount of water and electrolytes excreted increase proportionately. At the time when the water and the electrolytes that have been held in the blood stream and body fluids during this shutdown period have been completely excreted, the amount of electrolytes and the amount of water excreted cease to be proportional, and the urine concentration of one electrolyte may be great while that of another electrolyte may be slight. This period when water and electrolytes are no longer excreted in amounts which are proportional represents the final elimination of the accumulation of these substances in the body and a return to normal renal function.

The accompanying graph (fig. 1) shows the excretion of water and salts postoperatively in a patient who had an appendectomy for recurrent attacks of acute appendicitis. The appendectomy was performed as an interval appendectomy at a time when there were no acute signs of appendicitis. Similar graphs could be made for each of the other procedures during which these studies were made. Variations that occurred from one procedure to another were only in the length of

time that the renal shutdown lasted and in the length of time that was necessary for the kidney to eliminate the accumulated water and electrolytes. This latter phenomenon was also a function of the amount of salt and water that was administered postoperatively to a large extent. This indicated that some method of evaluating water requirements would be essential to an understanding of the need of the individual patient. While it is conceivable that deuterium studies might give such information, they were not available to us at the time; and in view of the work of others on the importance of body weight in relation to acute gains and losses of water, we began to use body weight alone as an indication of the water need of the individual patient.

The findings indicate that certain procedures which have been recommended for evaluating electrolyte and water requirements during the postoperative period can be of no value. It is obvious that urine chloride level and urine specific gravity can be of no benefit since during a variable postoperative period after all but the most minor procedures the output of electrolytes is proportional to the output of water and independent of the blood level. Thus the low specific gravity urine that occurs during the renal shutdown would suggest that electrolytes would be needed; however, determination of the electrolyte levels of blood indicates that they are rising, as a rule, during this period.

Similarly, chloride intake and output are useless because, even though the chloride loss is known to the nearest milligram, replacement is a matter of concentration in water as well as of total weight. It will be of no benefit to the patient to replace, milligram for milligram, the chloride which he loses unless one is able to determine the actual amount of water which should be replaced with the chloride. Thus in the last analysis, it becomes obvious that the concentration of salt in urine is a function of the ability and the activity of the kidney at the time rather than of the absolute blood level in the individual patient at that time.

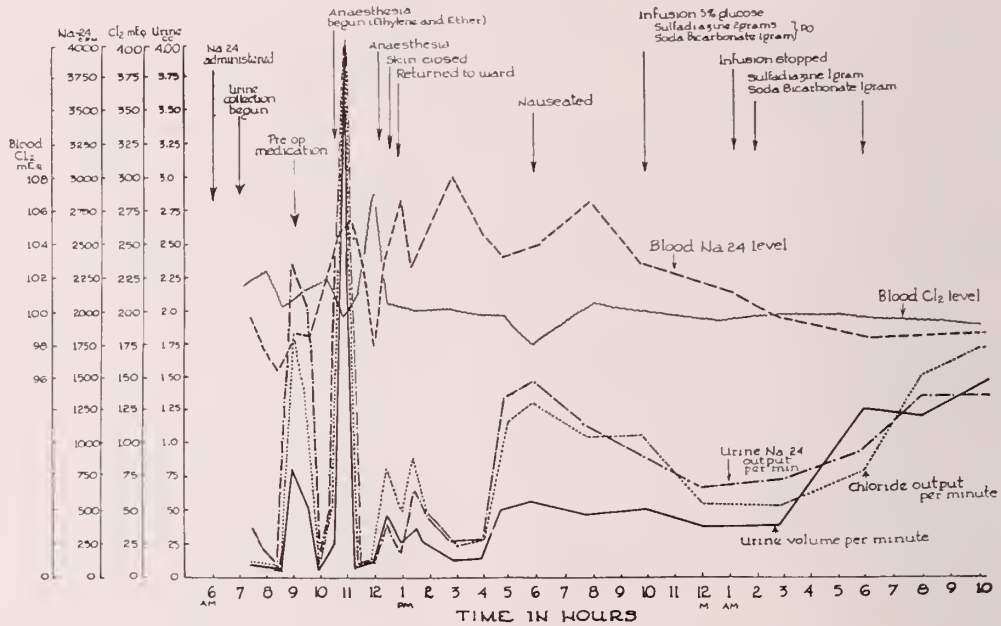


Fig. 1. — The excretion of water and salts postoperatively in a patient undergoing appendectomy is charted in this graph.

Formula

For these reasons, we have begun to use a fairly simple formula for calculation of salt and water need postoperatively. It is based on the following measurements: the daily water loss of the patient is determined by weighing the patient each day, beginning preoperatively and continuing postoperatively until the time that all danger of renal failure or water retention has ceased; water is replaced on the basis of 500 cc. per pound of lost weight; chloride and bicarbonate replace-

ment is given as indicated by the blood levels; sodium chloride and sodium bicarbonate are used. In order not to overload, chloride and sodium bicarbonate are given on the basis of 70 per cent of the dose calculated for the optimum replacement on the basis of total body weight. This method appears to be necessary since intercompartmental shifts are sometimes extremely slow.

For bicarbonate, the formula that we use is: $mM(NaHCO_3) = (60 - CO_2) \times .7W2.24$ where CO_2 is the serum carbon dioxide content and W is body weight in kilograms. One millimol of sodium bicarbonate equals 0.084 Gm.

For chloride the formula is: Gms(NaCl) = (592 - NaCl) 10 x 0.7 x W 1000 where NaCl is serum sodium chloride in milligrams per cent and W is weight in kilograms.

This amount of chloride and bicarbonate is given in whatever water is indicated by the weight loss of the patient. Finally, 48 hours after renal output begins to exceed 0.4 cc. per minute — which represents about 600 cc. in 24 hours — it is necessary to begin to maintain potassium at the rate of 1 Gm. per day. If the patient is unable to take oral feeding, potassium must be maintained by parenteral fluids. In all such cases glucose, 5 to 10 per cent up to 100 Gm. daily, is used to supply calories.

A Review of the Effects of Various Drugs On Human Cerebral Circulation and Metabolism

Peritz Scheinberg, M.D.
MIAMI

A wide variety of drugs has been used by physicians in the treatment of acute and chronic manifestations of cerebral vascular disease and other brain disorders with the hope of producing dilatation of cerebral blood vessels and thereby increasing the circulation to the brain. For the most part such usage has been empiric and based upon observations of the effects of these drugs in other parts of the body. The development of the nitrous oxide technic for measuring cerebral blood flow by Kety and Schmidt[1] in 1945 has permitted scientific evaluation of the physiologic effects of most of the commonly used so-called vasodilators on cerebral circulation. The nitrous oxide technic is an application of the Fick principle which permits measurement of cerebral blood flow in milliliters per minute per gram of brain tissue; from this basic information, cerebral oxygen and glucose consumption, cerebral vascular resistance, and other important cerebral metabolic functions can be measured.[1, 2] In all instances the studies were carried out in a similar manner, with the control observations made immediately prior to the administration of the drug being studied.

Of all the drugs studied, the most effective in increasing cerebral circulation are those which increase the carbon dioxide content and tension of the blood. Accumulating evidence indicates that arterial carbon dioxide tension is the most important chemical factor in the regulation of cerebral circulation. Inhalation of a gas mixture containing 5 per cent carbon dioxide results in a 70 per cent increase in cerebral blood flow, with no change in cerebral oxygen consumption, but a corresponding reduction in cerebral vascular resistance.[3] This increase in cerebral blood flow results if the carbon dioxide gas mixture contains varying quantities of oxygen, from 21 per cent to 95 per cent. Increasing the concentration of carbon dioxide in the gas mixture from 5 per cent to 10 per cent results in even greater cerebral vasodilatation, but the excessive hyperventilation induced by the larger concentrations of carbon dioxide makes it possible to administer the gas for only a few minutes at a time, whereas most persons can comfort-

From the Department of Physiology, University of Miami School of Medicine, Coral Gables.

ably inhale a 5 per cent carbon dioxide mixture for as long as 20 to 30 minutes, and the inhalation can be repeated at frequent intervals. It is of interest in this respect that simple overventilation, with resultant blowing off of carbon dioxide and reduction in arterial carbon dioxide tension, produces intense cerebral vasoconstriction,[4] a phenomenon which may be partially responsible for some of the clinical symptoms of the hyperventilation syndrome and for the appearance of abnormal electroencephalographic patterns and even convulsions in epileptics who undergo hyperventilation.

Intravenous administration of 3 per cent $NaHCO_3$, resulting in metabolic alkalosis with increased arterial carbon dioxide tension, produces an increase in cerebral blood flow similar in magnitude to that resulting from inhalation of 5 per cent carbon dioxide.[5] Administration of $NaHCO_3$ in clinical practice must be tempered by the knowledge that the Na + ion results in fluid retention, which could be harmful in certain types of patients. Though both CO_2 and $NaHCO_3$ are powerful cerebral vasodilators, they have little or no influence on other parts of the peripheral vascular tree, indicating the specificity of response of cerebral vessels to certain chemical stimuli.

Papaverine administered intravenously in doses of 0.2 Gm. results in only moderate cerebral vasodilatation, with a 13 per cent increase in cerebral blood flow.[6] The action of the papaverine is probably directly on cerebral vessels, though it is well known that this drug also produces vasodilatation in other parts of the body. Papaverine can be given orally in fairly large quantities and at frequent intervals, and although its effect by this route of administration has never been accurately measured, it is assumed that it is effective as a mild cerebral vasodilator.

Intravenous nicotinic acid, a drug widely used in the treatment of vascular disease of the brain, produces no measurable change in cerebral blood flow or vascular resistance despite the pronounced facial flush which results from it.[7] This is another indication that inferences concerning the effects of any drug on cerebral circulation cannot be drawn from its apparent effects on circulation elsewhere in the body. It is difficult to explain many of the reported beneficial clinical effects of nicotinic acid in the treatment of cerebral vascular disease, but the psychologic effect of the intense facial flush must be remembered.

Priscoline is another drug which produces considerable increase in circulation to the skin of the extremities, and probably also to the muscles, with no apparent beneficial effect on cerebral circulation.[8] Priscoline may actually produce mild cerebral vasoconstriction. Aminophylline and caffeine are both frequently used in the treatment of cerebral vascular accidents, yet both drugs result in cerebral vasoconstriction and reduction in cerebral blood flow,[9] indicating that they may actually be prejudicial to the patient. This result is also true of 100 per cent oxygen by inhalation,[3] which is frequently used in the treatment of all varieties of brain disorders. It does not imply that oxygen is harmful when its use is indicated, such as in diminished arterial oxygen saturation due to impaired oxygen transfer across the pulmonic alveolar-capillary membrane, but it does indicate that 100 per cent oxygen is not harmless and should not be used indiscriminately.

Intravenous histamine produces no significant effect on cerebral blood flow and does not result in dilatation of cerebral vessels unless there is a concomitant fall in peripheral arterial pressure.[9] It would appear therefore to be of little value in the treatment of disorders of cerebral circulation. It is also somewhat surprising to learn that moderate amounts of ethyl alcohol, sufficient to result in mild intoxication, produce no effect on cerebral blood flow and metabolism, although larger quantities greatly depress cerebral metabolism.[10] This finding would indicate that the use of whisky to produce "cerebral stimulation" may have adequate psychiatric justification, but there is no evidence to indicate that it results in cerebral vasodilatation or increased metabolism of brain cells.

Procaine has been used intravenously by some physicians in the treatment of cerebral vascular disorders, but this drug has no appreciable effect on cerebral blood flow. Indeed, it may actually induce moderate cerebral vasospasm.[11] The discussion of procaine usually leads to a consideration of stellate ganglion block by procaine, a procedure widely used in the treatment of "strokes," both acute and old. It has been demonstrated that stellate ganglion block produces no increase in cerebral blood flow or alteration in cerebral vascular tone in normal persons and in patients with varying degrees of cerebral vascular disease.[12,13] As a matter of fact, there is no objective evidence that the sympathetic innervation of the cerebral vessels plays any role in regulating the tonus of those vessels. It must be remembered, however,

that physiologic studies have not been made on subjects with reactive cerebral vessels that may be in a state of increased tone due to some harmful stimulus, such as a young person with mitral stenosis and resulting cerebral embolism. The indiscriminate use of stellate blocks must be deplored, however, for the procedure is not without hazard, and the presence of cerebral hemorrhage, a distinct contraindication to stellate block, cannot always be detected clinically even by the most practiced observer.

Summary

In summary, the effects on cerebral circulation and metabolism of drugs commonly used in the treatment of cerebral vascular disease have been reviewed. Though laboratory observations and clinical results do not necessarily agree, the physician still should choose his therapeutic armamentarium with a view to providing a definite physiologic result, rather than depending upon empiric procedures which may derive from poorly controlled, inconclusive clinical observations. Much is yet to be learned concerning appropriate therapy for cerebral vascular disease and other brain disorders, but the intelligent clinical application of drugs and procedures shown to be physiologically sound may provide the beginning of a solution to some of these problems.

References

1. Kety, S. S., and Schmidt, C. F.: Determination of Cerebral Blood Flow in Man by Use of Nitrous Oxide in Low Concentrations, Am. J. Physiol. 143:53-66 (Jan.) 1945.
2. Scheinberg, P., and Stead, E. A., Jr.: Cerebral Blood Flow in Male Subjects as Measured by Nitrous Oxide Technique. Normal Values for Blood Flow, Oxygen Utilization, Glucose Utilization, and Peripheral Resistance, with Observations on Effect of Tilting and Anxiety, J. Clin. Investigation 28:1163-1171 (Sept.) (pt. 2) 1949.
3. Kety, S. S., and Schmidt, C. F.: Effects of Altered Arterial Tensions of Carbon Dioxide and Oxygen on Cerebral Blood Flow and Cerebral Oxygen Consumption of Normal Young Men, J. Clin. Investigation 27:484-492 (July) 1948.
4. Kety, S. S., and Schmidt, C. F.: Effects of Active and Passive Hyperventilation on Cerebral Blood Flow, Cerebral Oxygen Consumption, Cardiac Output and Blood Pressure of Normal Young Men, J. Clin. Investigation 25:107-119 (Jan.) 1946.
5. Schieve, J. F., and Wilson, W. P.: Changes in Cerebral Vascular Tone in Experimental Metabolic Alkalosis and Acidosis, J. Clin. Investigation 31:659 (June) 1952.
6. Jayne, H. D.; Scheinberg, P.; Rich, M., and Belle, M. S.: Effect of Intravenous Papaverine Hydrochloride on Cerebral Circulation, J. Clin. Investigation 31:111-114 (Jan.) 1952.
7. Scheinberg, P.: Effect of Nicotinic Acid on Cerebral Circulation, with Observations on Extracerebral Contamination of Cerebral Venous Blood in Nitrous Oxide Procedure for Cerebral Blood Flow, Circulation 1:1148-1154 (May) 1950.
8. Scheinberg, P.; Blackburn, I., and Rich, M.: Effects of Intravenous Priscoline on Cerebral Blood Flow and Metabolism, J. Clin. Investigation in press.
9. Shenkin, H. A.: Effects of Various Drugs upon Cerebral Circulation and Metabolism of Man, J. Appl. Physiol. 3:465-471 (Feb.) 1951.
10. Battey, L. L.; Patterson, J. L., Jr., and Heyman, A.: Effects of Methyl and Ethyl Alcohol on Cerebral Blood Flow and Oxygen Consumption, Am. J. Med. 13:105 (July) 1952.
11. Scheinberg, P.; Jayne, H. W.; Rich, M., and Belle, M. S.: Effects of Intravenous Papaverine and Procaine on Cerebral Circulation and Metabolism, J. Clin. Investigation 30:671 (June) 1951.
12. Harmel, M. H., and others: Effect of Bilateral Stellate Ganglion Block on the Cerebral Circulation in Normotensive and Hypertensive Patients, J. Clin. Investigation 28:415-418 (May) 1949.
13. Scheinberg, P.: Cerebral Blood Flow in Vascular Disease of Brain, with Observations on Effects of Stellate Ganglion Block, Am. J. Med. 8:139-147 (Feb.) 1950.

1431 North Bayshore Drive.

Proceedings of Seventy-Ninth Annual Meeting

Scheduled for Publication

in the June Issue

Intramedullary Fixation of Fractures of Long Bones

JOHN T. ELLIS, M.D.*
AND
SAMUEL W. WINDHAM, M.D.
DOTHAN, ALA.

The procedure of intramedullary fixation in fracture was first reported by Lambotte in 1907. He employed screws in fractures of the clavicle and in subtrochanteric fractures of the femur. Ivory and bone pegs were employed by König in 1913. In 1918, Groves reported 3 cases of fracture in the proximal third of the femur which had been fixed by the use of medullary nails. According to Soeur, intramedullary Kirschner wires were used by Dennis and also by Jolley for fractures of bones of the forearm, metatarsals, and other small bones. In 1937 and again in 1939, Rush and Rush reported the use of Steinman pins in the intramedullary canal of the ulna and of the femur. Lambrinudi in 1940 reported the use of wires in the forearm and multiple wires in the femur. In the same year Murray reported the use of wires in the clavicle. In 1947, Wheeler, cited by Street, reported his experience with femoral fracture fixation using multiple intramedullary wires.

In the early nineteen thirties, Böhler predicted that treatment similar to the internal fixation of fractured femoral necks would, at some time, be used in the treatment of fractures of long bones. Küntscher stimulated worldwide interest in this method of fracture fixation when he introduced to the medical profession in 1939 the use of intramedullary pins similar to those in use at the present time. His pins were made of stainless steel, were rigid enough in construction to hold the fractures in alignment and occupied most of the intramedullary canal.

Because of the delay in medical periodicals reaching this country during the war years, it was not until 1945 that this method of treatment began to receive much attention by American doctors. The Hansen Street diamond-shaped nail was described and introduced in 1945. It was used in 4 cases of fractured femur that year. Westerborn introduced his modification of the Küntscher nail in 1948, and the Rush round pin for spring type fixation was described and introduced in 1949. Thus, in spite of the fact that this method of treatment was reported as early as 1907, most of the work has been done during the past decade.

Advantages of the Rush Nail

We began using intramedullary fixation of fractures of long bones in 1949. This was soon after Rush's nail was introduced, and after careful study of the information available at that time, it was decided that the Rush nails would be the type we would use for internal fixation. To us, the advantages of the Rush nails are: (1) The versatility of the nails — they can be used in all types of long bone fractures. (2) The armamentarium necessary to fix fractures with the nails is minimal. (3) The relative ease in choosing the proper size and length of nail to be used makes it unnecessary to have a large collection of nails on hand in order to fix all fractures sustained by patients. (4) The Rush nail does not occupy and completely fill the medullary cavity so that muscle contraction can be depended upon to bring about the important factor of continuous compression of the bone ends or fragments so necessary to bone healing. (5) The simple hook construction of the proximal end of the Rush nail prevents it from protruding into the soft issue with the complications resulting therefrom. These complications have been described as limitation of hip motion, bursitis, and the occurrence of bursal sacs about the end of the protruding nail. The hook also can be partially embedded in the bone, thereby preventing migration of the nail.

*Chief Surgeon, Atlanta and St. Andrews Bay Railroad Company, Frasier Ellis Hospital, Dothan, Ala.
Read before the Florida Association of Industrial and Railway Surgeons, Thirteenth Annual Meeting, Hollywood, April 27, 1952.

Indications for Intramedullary Fixation

The indications for the use of intramedullary fixation are still of paramount importance if the relatively new method of fracture fixation is to maintain its place in fracture treatment. They should be rather clearcut and followed. Some enthusiasts for this method of treatment use it for any type of fracture. This indiscriminate use is certain to cause criticism of the method in spite of its apparent advantages over the conventional methods of fracture fixation. This method is most effective in fractures of long bones in their middle two thirds. The ideal fracture for fixation is the fractured femur at the isthmus or narrowest portion of the intramedullary canal, which is usually just below the junction of the upper and middle third. Böhler limited intramedullary fixation of femoral fractures to the area below 7 cm. from the tip of the great trochanter and 7 cm. above the knee joint. These are not absolute limits, but should serve to indicate that the closer the fracture line approaches either extremity of the bone, the less secure is the fixation and the more likely is the occurrence of postoperative complications, fragment displacements and poor healing.

Soon after the introduction of the method, spiral fractures were thought to be contraindications for this method of treatment. This opinion was due to the frequent telescoping and displacement of fracture fragments. Now by the use of stabilizing screws or encircling Parham band or wire, these fractures can be satisfactorily treated by this method. In the use of supplementary fracture fixation material, one should be sure that the screws do not engage and fix both the upper and lower fracture fragments so that one of the prime advantages of the method, namely, continuous compression of the fracture fragments secondary to muscle contraction, would be neutralized. These remarks are as applicable to comminuted fractures as to spiral fractures, and here again, supplementary fixation material should be used to fix the major comminuted fragments to the principal fracture fragment. Segmental fractures are particularly amenable to this form of treatment, since it is easy to fix the fragments securely by threading them over the intramedullary nail.

When intramedullary fixation was first introduced, compound fractures were thought to be contraindications to the use of this fixation method. At the present time we do not hesitate to fix compound fractures immediately, being certain, however, that debridement and proper toilet of the wound are carried out at the time of fracture fixation and that the patient is protected adequately by antibiotic therapy. We have had no regret for adopting this attitude, and in all instances the soft tissue wounds and fractures have gone on to uneventful healing. To date, we have had no postoperative infections in our cases.

Another ideal situation for intramedullary fracture fixation is in patients with multiple injuries. Intramedullary fixation is ideal in the treating of delayed union and nonunion. It is true that bone graft and bone chips are frequently used as supplementary aids in the healing of ununited fractures, but the intramedullary fixation maintains the fracture in alignment and produces a much more ideal situation in which to use the supplementary procedures.

Advantages and Disadvantages of Intramedullary Fixation

The advantages of intramedullary fixation are as follows: (1) No external fixation is necessary except when the fractures are in close proximity to joints, and even in these situations, with the more recent methods of fixation, casting is unnecessary. (2) The adjacent joints can be kept mobile, preventing limitation of motion and periarticular adhesions. (3) The patient can be made ambulatory early in the treatment, thereby reducing hospital stay, hospital cost and nursing service. (4) There is no muscle atrophy due to disuse because of the maintained activity in the extremity containing the fracture, and because of no joint stiffness or muscle atrophy no rehabilitation is necessary. The patient continues to use his muscles voluntarily and in cases in which voluntary use is not performed, it is encouraged and insisted upon. In spite of the fact that full weight bearing is not permitted in the immediate postoperative period, it is usual that patients with lower extremity fracture be ambulatory at seven to 10 days, using crutches. (5) This method of fixation eliminates the detrimental factors of the traction and sharing forces at the fracture site, but maintains the favorable pressure factors through muscle action bringing the fracture fragments into close and constant apposition. (6) No distraction as a result of absorption at the bone ends occurs. When external fixation in the form of plates or screws is used, it is not unusual for absorption at the bone ends to occur, resulting in separation of fracture

fragments due to the rigid fixation of this form of treatment, thereby often resulting in delayed union or even nonunion.

The disadvantages of this method of fixation are: (1) It requires open operation. In modern hospitals with adequate operating room facilities, this should not present a problem because infection should be extremely rare. Some advocate closed reduction and fixation by fluoroscopic control. We are opposed to this method of treatment, and think that all operations should be performed as an open procedure. (2) In the tibia and bones of the forearm there are differences in the width of the medullary canals in the ends and center of the bone. For this reason pins of uniform size may permit lateral displacement and axial rotation at the fracture site. With supplementary fixation and use of multiple pin procedures, this disadvantage can be eliminated. (3) It produces trauma at the vital bone healing area — the fracture site. It is known that the presence of a hematoma at the site of fracture is an adjunct to bone healing. When this procedure is used, the hematoma is removed. (4) There is a controversy over the question of whether or not intramedullary fixation hinders callous formation. Early in the use of this method it was thought that it does. Recent experimental work tends to disprove this original opinion.

Selection of Cases

In the selection of cases for this type of treatment, children are usually excluded. Open reduction is rarely indicated, and a pin should not unnecessarily be driven across the epiphyseal line for fear of growth disturbance. Under certain circumstances in which the fracture is such as to justify the risk, this procedure might be used; however, in treating essentially long bone fractures, which is the subject under discussion, it has no place in the treatment of this type of fracture in children. Age is an indication rather than a contraindication for this type of fixation. It is not unusual to have elderly patients enter the hospital in moderate to severe shock secondary to a long bone fracture and to have them actually improve as soon as the fracture has been stabilized. The deleterious result of bed rest in the aged is known to all, and this method of fixation permits early ambulation, thereby avoiding the complications of bed rest in this age group.

We strongly believe that treatment of fractures by this method of fixation should be carried out as soon after the accident producing the fractures as possible. Shock must be treated and the patient's general condition made ready for surgery before the operative procedure is performed, but as soon as the general condition permits, we think that the fracture should be openly reduced and fixed. If these fractures are seen late, standard traction methods should be used until the swelling about the fracture site has disappeared, but this form of treatment should not be continued until callous formation has begun.

Technic

The technic used in intramedullary fixation is relatively simple and will be briefly described for fixation of the femur, the tibia, the radius and ulna, and the humerus.

In the fixation of femoral fractures the patient is placed supine on the operating table, a lateral incision is made over the fracture site exposing the major fracture fragments. The Rush nail is introduced through either one of two points, namely, the superior surface of the great trochanter or the lateral surface of the bone just below the great trochanter. A small stab wound is made over the point of entrance, and a drill hole slightly larger than the diameter of the pin is made in the cortex of the bone. The point of the pin is pushed through this drill hole obliquely until it enters the medullary canal. Little resistance is met until the gliding surface of the sled runner point strikes the medial cortex of the femur. It then begins to glide down the intramedullary canal and is usually easily driven down the bone. It is driven down the medullary canal until the point presents at the site of fracture. The fracture fragments are then brought in line, the sled runner of the pin is introduced into the distal fracture fragment and is simply driven into place by light taps on the head of the pin with a mallet. An effort is made to align perfectly the fracture fragments before the pin is completely driven in. When the proper length of pin has been selected, the hooked head lies beneath the soft tissue and firmly grasps the cortex of bone, thereby preventing axial twisting of the pin. The wound is then closed. We prefer chromic catgut in the fascial layers and either nylon or silk in the skin.

In the case of the humerus, open operation is performed through as small an incision as possible. In the technic of all pin applications subperiosteal dissection of the bone at the site of fracture is unnecessary. The fracture fragments of the humerus are exposed, and a small stab wound is made over the tuberosity of the humerus in line

with the fibers of the deltoid muscle. A 3/16 inch drill hole is made at this point in a slightly oblique direction; through this drill hole the sled runner point of the Rush nail is introduced and the nail is gently tapped with a mallet until the sled runner presents itself at the site of fracture. The fracture fragments are then accurately reduced; the sled runner is directed into the medullary canal of the distal fragment and is driven home. The same position and advantages of the hooked head are applicable to the humerus as to the femur. Because of the differences in the size of the intramedullary canal, a 1/4 inch nail is usually used in the femur whereas a 3/16 inch nail is used in the humerus.

In the case of the tibia, a similar technic is used and either a 3/16 inch or 1/4 inch nail is used, depending on the size of the medullary canal. An oblique drill hole is placed in the surface of the tibia just below the tibial tuberosity, and the same general principles of driving the nail into place are used.

In fixation of fractures of the radius and ulna, certain dynamics of muscle power must be considered. In fractures of the shaft of the radius in its upper third, the upper fragment is supinated while the lower fragment is pronated. Thus, when longitudinal pinning is done, the pin should be driven into the upper fragment of the radius with the forearm in supination. In fractures of the lower two thirds of the radius, this position of fracture fragments is not found because of the balancing action of the muscle upon this portion of bone. The bone is usually in a neutral position in regard to supination and pronation, and consequently these fractures should be pinned with the radius in a neutral position. In fractures of the ulna these muscle imbalances are not present, and there is the lack of the tendency toward wide separation of the fracture fragment as is noted in radial fractures. Thus, the position of the forearm is of no special importance. In fractures of both bones of the forearm the typical radial fracture displacements as described tend to be present, and there is a tendency toward overlapping of the fracture fragment. The lower fragments also tend to approach each other because of muscle action. These characteristic positions of the fracture fragments must be kept in mind to perform properly intramedullary fixation.

A 2/16 inch nail is usually used in the fixation of lower arm fracture fragments. The arm is draped over the chest, and we prefer open reduction in all cases. Ulna fracture fragments are exposed through a medial incision. A small stab wound is made over the posterior surface of the olecranon process, and a 2/16 inch drill hole is made in the cortex of the bone. Through this opening a pin of sufficient length to extend well into the distal fragment is introduced and driven into the bone until the point is seen to emerge at the fracture site and by angulation and manipulation, the fracture is reduced and the pin is driven well into the distal fragment. In the ulna, because the bone is straight, there may be some tendency of the distal fragment to rotate when the fracture is located in the lower portion of the shaft, but if the pin is driven well into the distal fragment, rotation is not likely to occur. In radial fracture the fracture site is exposed through a posterolateral incision, and with the wrist flexed the styloid end of the radius is palpated. Over this point a stab wound is made and a 2/16 inch drill is then passed vertically into the bone until the cortex is broken and until the drill point is in the medullary canal. A pin of suitable length is then introduced through the drill hole until it strikes the distal cortex of the shaft. The medullary canal of the radius is curved, frequently being slightly S shaped, and as the pin is tapped with a hammer, it may rotate as the sled runner point glides up the uneven contour. If the driving of the pin becomes difficult, simple rotation of the pin or withdrawing the pin a short distance, rotating it and driving it in a different direction will usually permit it to be easily driven up the canal. With the forearm in positions described for the different radial fracture sites, the pin is then driven into place. All wounds are then closed.

Postoperative Care

Postoperative care is greatly simplified. We use no compression type dressings in any extremities in which intramedullary nailing has been performed. When the lower extremity is involved, the patients are permitted out of bed using crutches on the seventh to tenth day, and when reluctance on the part of the patient is encountered, ambulation is insisted upon. At the end of approximately three weeks, partial weight bearing is permitted and full weight bearing is allowed in six to eight weeks. In forearm fractures the patient is permitted out of bed on the first postoperative day, and the arm is simply carried in a sling. In humeral fractures, this same procedure is followed. The remainder of the postoperative care is simply that of the care of the soft tissue

wound. We insist that all patients eat a high protein diet because of the known tendency for the development of a negative nitrogen balance and hypoproteinemia in patients subjected to traumatic wounds.

The pins are left in place until there is roentgen evidence of solid union regardless of the time required. We are conservative in the time element of their removal as we believe that the presence of the pins in the intramedullary canal produces no harm and therefore there is no hurry about their removal. In forearm fractures, the patients occasionally complain that complete extension of the elbow joint or dorsiflexion of the wrist joint is somewhat hampered by the presence of the hooked head of the pin, but otherwise they are unaware of the presence of the pin. It should be stressed again that the pins are left in place until solid bony union, as demonstrated by roentgenogram, has occurred.

Complications

Complications following this method of fracture fixation have been extremely few in our hands. In tibial fractures there has been an occasional case in which excess callous formation has occurred at the fracture site. We believe that this is due to the trumpet shape of the medullary canal, thus permitting excessive motion at the fracture site. It would be well in these fractures for the patient to wear a light cast for a period of time until the fracture fragments have become partially fixed, thereby preventing excessive motion, and in so doing prevent excessive callous formation.

One complication which has been somewhat distressing in our cases has been the rather massive and somewhat persistent postoperative edema in the extremity involved. This has not occurred in fractures of the humerus, but has predominated in both bone fractures of the forearm and in fractures of the tibia. We do not use elastic support of the extremity and do not believe that this type of support prevents the formation of this postoperative edema; yet we have no adequate explanation for its occurrence. We have seen no specific ill effects come of this edema in that it does gradually disappear before chronic skin changes, ulceration, or other changes develop, but it is an annoying, unexplained complication. Most of the complications as described in the literature seem to be avoided through the use of the round spring type Rush nail.

In our cases there has been no postoperative infection. We have had one pin to break in a humeral fracture at the fracture site. In this case, nonunion had occurred secondary to a plating procedure on the humerus. The plate had been removed and an intramedullary pin put in place, and several months after its application and in the presence of a persisting nonunion the pin was broken. The pin was removed, its removal being a relatively easy procedure, and it was replaced by another pin of a similar type. In another humeral fracture there was bowing at the fracture site, lateral displacement of the fracture fragments and a deformity created at the fracture site, but this result was secondary to the improper application of the fixation material and cannot be considered as a defect of the method when properly performed. To us, the fractures heal at about the same rate with this method of treatment as with the conventional methods of fracture therapy.

The cases reported illustrate a number of the principles, hazards and complications involved in this type of fracture fixation.

Report of Cases

Case 1. — Mr. B. M. B., a 17 year old, white youth, was hospitalized on March 10, 1950 because of multiple injuries sustained when the scooter on which he was riding was struck by a truck. On arrival at the hospital he was in moderate shock and had a compound fracture of the middle third of the right femur with bone protruding through the soft tissue defect and a compound, comminuted fracture of the right patella. The examination otherwise gave essentially negative results. He arrived at the hospital at approximately 7 p.m., was given 1,000 cc. of whole blood and prepared for surgery. At approximately 8:30 p.m. on the night of admission, he was operated upon. The compound wound was thoroughly debrided, and a 1/4 inch Rush intramedullary nail was put in place in the compound fractured left femur; the compound fractured patella was debrided, several small comminuted fragments of bone were removed, and the patella was wired. The postoperative course was entirely satisfactory, and no evidence of infection developed.

This case illustrates the use of a Rush nail in a youth 17 years of age who had a compound fracture of the femur and an additional compound fracture of the patella on the same side. The epiphyseal line in the upper end of the femur had closed, and because of this closure he was treated as if he had been an adult. The epiphyseal line at the distal end of the femur had not closed, and it was anticipated that the nail would not bridge that portion of the bone. It did, however, and up to the present time, he has had no adverse effect on epiphyseal line closure or bone growth. Through the use of this method of treatment he was able to follow the routine schedule of knee joint movement as used in fractured patella. Had some type of cast treatment been used, it is believed that he would definitely have had at least a pronounced limitation of motion at the knee

joint. At the present time the patella and femur are solidly united, and there is no limitation of motion at the knee joint. Figure 1 illustrates the original fractures and their progress until united. We believe strongly that the early treatment beginning with adequate resuscitation from shock, thorough debridement and cleaning up of the compound wound, fixing of the fracture fragments in position and early motion at the knee joint produced the excellent result obtained in this case.

Fig. 1. — The fracture as seen on admission and the end results.

Case 2. — Mr. L. P. S. was hospitalized on Aug. 16, 1949 because of an injury to the right femur, sustained on June 14 when the left leg was struck by a log, pinning it between the log and the ground. He was immediately admitted to another hospital, where he was treated by skin traction for 10 days. He was then anesthetized, and a cast, the remnants of which can be seen on close inspection of figure 2, was applied to the injured leg. It was the patient's impression that he had no leg shortening and the toes and patella were in proper position prior to casting. Soon after the cast was applied, he noticed shortening and internal rotation of the right lower leg. On his arrival at Frasier-Ellis Hospital, the right leg could only be described as in a frog leg-like position. On examination there was a large, palpable, bony deformity in the middle third of the right femur with the leg bowed, giving the impression of a frog's leg. The muscles of the thigh were markedly reduced in size as was true of the muscles in the lower leg. There was an infected ulcer on the medial aspect of the right knee joint area which measured approximately 4 by 2 cm., and foul-smelling pus was exuding from the area of ulceration. On the anterior, lateral, medial and posterior aspects of the lower two thirds of the right lower leg there were encrusted abrasions measuring up to 4 by 5 cm. The right foot was in a pronounced equinovarus position and fixed in that position.

On the day of admission the cast was removed, the leg was thoroughly scrubbed, and the infected ulcer was debrided and dressed; a Steinman pin was placed through the os calcis and 18 pounds of weight were applied as skeletal traction. This was continued for four days with some slight correction of the deformity at the fracture site. The infected ulcer and skin were treated until clean and granulating, and on August 26, 10 days after admission, he was operated upon. The fracture site was exposed, the callus excised, the bone end freshened, and the medullary canal opened; a Rush intramedullary nail, by the technic described, was then put in place. The postoperative course was uneventful, and on Oct. 30, 1950 he was finally persuaded to return for follow-up study. A roentgen examination at that time demonstrated solid bony union. He had been ambulatory since 10 days following the operation, and the limb had been bearing-weight for an undetermined period of time. The only residual disability was in the right ankle, where there was an estimated 10 per cent limitation of dorsiflexion of the right foot and the right lower leg. Treatment was offered for this, but the patient was completely happy with the result and refused further treatment.

This case illustrates what will always happen when such a cast as was applied to this leg is applied to a fractured femur. We all know that adequate spica casts will not hold a fractured femur in position. In spite of the fact that the fracture was nine weeks old, the medullary canal could be easily opened, and the application of the nail was relatively easily performed. This method of treatment provided a convenient and completely satisfactory method of treatment in this badly deformed, neglected, fractured femur.

Fig. 2. — The position of the fracture fragments when first seen, following skeletal traction, immediately postoperative, and when the fracture had healed.

Case 3. — Mrs. E. B. S., a 38 year old, white widow, was hospitalized on May 22, 1950, approximately 18 hours after injury. She had sustained injury to the left forearm, upper part of the left leg and scalp and multiple soft tissue injuries of the extremities and body. Roentgen examination demonstrated a simple transverse fracture of the middle third of the left ulna, which was in satisfactory position in a plaster of paris cast. Also demonstrated was a segmental fracture of the upper half of the left femur with the proximal fracture site in the subtrochanteric area and the distal fracture site at approximately the junction of the upper and middle third of the femur. The intervening fracture segment was split, and there was a large piece of bone broken off of the proximal fracture fragment just above the proximal fracture site. Traction was applied to the fractured femur for a trial period with completely unsatisfactory results.

Fifteen days after hospitalization, the patient was operated upon, and the femoral fracture sites were exposed through a long lateral thigh incision. The comminuted fragment located at the proximal fracture site was fixed

in position with an SMO screw, and a Rush intramedullary nail was put in place bridging both fracture sites. The piece of bone comprising the segmental fracture was found to be split and separated, and after the nail had been threaded through the segment, it was accurately reduced and fixed with the use of a screw. A circular wire was then applied around the distal end of the segment and the distal fracture fragment, because of the somewhat spiral fracture at that site. Because of the extensive surgical procedure performed, the wound was drained. It is questionable whether or not this was necessary or proper. Because of the closeness of the fracture fragment to the upper end of the femur and the presence of the intervening fracture segment, this patient was put in a single leg spica cast in which she stayed for approximately eight weeks.

In spite of the cast, and in spite of the circular wiring, a slight telescoping at the distal fracture site occurred. On close inspection of figure 3, it can be noted that the intramedullary nail was too short to be considered perfectly applicable. Healing was effected, and in spite of the fact that the patient was only in a cast for approximately eight weeks, her only disability at the present time is a moderate limitation of motion at the knee joint. The lesion is now completely healed, the pin has been removed, and she is back at work as a secretary. She has the disability noted, but there are no complaints referred to the femoral fracture.

This case illustrates the effectiveness of intramedullary fixation in segmental fractures as well as the use of encircling wire and screws as adjuncts in fixation.

Fig. 3. — The original position of fracture fragments, the immediate postoperative condition of these fragments, and periodic roentgen examinations during the course of healing until the fracture had solidly united.

Case 4. — J. G., a 47 year old, married, Negro farmer was hospitalized on July 14, 1950 because of an injury to the left upper arm, which was sustained approximately six weeks before admission when he fell from a height of 8 feet, landing on his left hand and forearm. Roentgen examination at the time of injury demonstrated a fracture of the left humerus. The arm was placed immediately in a hanging cast. Two weeks after the application of the cast a roentgen check-up examination was made, and distraction at the fracture site was demonstrated. The cast was removed, and a second lighter hanging cast was applied. He had worn the second cast for approximately four weeks when first seen by us. Roentgen examination demonstrated a continued distraction, a moderate amount of callous formation about the fracture site, poor alignment of fracture fragments, and severe swelling in the left hand and forearm.

On his admission to the hospital the hanging cast was removed, and he was operated upon. The fracture site was exposed through a lateral incision, the excess callus was removed, the bone ends were freshened, and a 3/16 inch Rush pin was put in place by means of the technic described. Figure 4 illustrates the original and final positions of fracture fragments.

The patient was discharged from the hospital on July 18 with his arm in a sling but with no other type of fixation. The fracture went on to solid bony union with no limitation of motion at the shoulder or elbow joint.

This case illustrates the hazards of hanging cast treatment of fractured humeri. On close scrutiny, in spite of the fact that the fracture is in ideal position, the pin applied could have been a little longer and the comminuted fractured fragment on the medial aspect should have been fixed in position with a circular wire or a Parham band. Because of the relatively weak muscle pull in the upper arm, telescoping did not occur in this case. Had this fracture been in the femur, we would have definitely expected such an occurrence.

Fig. 4. — Position of distraction produced by hanging cast and the immediate postoperative position of the fracture fragments.

Case 5. — Mrs. V. S., a 39 year old white woman, was first seen in September 1945, approximately six months after injury to the left upper arm. She had been treated for six months by hanging cast to which 5 pounds of weight were attached in the elbow region. This resulted in nonunion, and as soon as the cast was removed, deformity and motion at the fracture site were noted. On her first hospital admission the fracture was exposed, excess callus removed, and fracture ends freshened, reduced and plated. A cast was applied to the arm, and she was discharged from the hospital after an essentially uneventful postoperative course. Approximately six weeks thereafter she was admitted a second time for the purpose of changing the cast. At that time the fracture fragments were in good position, being held in position by the bone plate. She was then lost sight of until March 1949, having had the cast removed by her local physician. On examination at this time the plate and fixation screw were in good condition, but nonunion persisted. Because of this she was admitted for removal of the plate and intramedullary fixation of the fracture. The postoperative course was uneventful, and she was discharged with no cast support to the arm. After the application of the intramedullary nail she could do all of her housework with no difficulty. Approximately 10 months thereafter, following the direct application of force to the left upper arm, the fracture was noted to be unstable. On roentgen examination it was observed that the nonunion persisted and that there was a complete break of the intramedullary pin at the fracture

site. She was again admitted to the hospital for the removal of the broken nail and the reapplication of the same type of intramedullary fixation. This procedure was carried out with relative ease, and she was discharged from the hospital. The nonunion at the fracture site has persisted, but she has refused any further treatment because of her ability to do all of her housework and because the arm is stable and painless. Figure 5 illustrates the course of this ununited fractured humerus in spite of the multiple methods of treatment used.

Fig. 5. — Nonunion after plate fixation. Postoperative position of fracture after intramedullary fixation. Also illustrated is a break in the intramedullary pin followed by the removal of the broken pin and the application of a similar intramedullary pin. Nonunion is still present.

This case illustrates the multiple hazards in the treating of a fracture of the humerus. Hanging cast treatment was completely unsatisfactory because of displacement of fracture fragments and distraction. This form of treatment was carried on for a period of approximately six months before the original plating procedure was performed. The plate produced a rigid fixation of the fractured fragments with the fragments in a position of slight distraction. This distraction resulted in nonunion. Intramedullary fixation of the fracture did not result in union, and the direct application of force to the arm in the presence of nonunion resulted in a fracture of the intramedullary pin. This is the only instance in our experience in which an intramedullary pin has broken. The pin fragments were removed. A similar pin was placed in the humerus but with a persisting distraction. The nonunion has persisted. This experience demonstrates that some other type of treatment is necessary in many cases of nonunion in spite of the fact that intramedullary fixation is used. Intramedullary pin fixation plus bone chips or massive on lay bone grafts will be required before union can be obtained.

Case 6. — Miss P. J., a 32 year old white woman, was first hospitalized on July 16, 1950, approximately one hour following an automobile accident in which she sustained multiple injuries. On arrival at the hospital she was in moderate shock, complaining of pain in both arms, right elbow joint area, left shoulder and left ankle. There were extensive lacerations of the forehead and bridge of the nose. She had had poliomyelitis with a residual paralysis of the left lower extremity, and the left ankle joint had been stabilized approximately two years before the accident in which she sustained the present injury.

One thousand cubic centimeters of whole blood was given immediately, and as soon as her condition improved, the extensive lacerations of the forehead and nose were debrided and closed primarily. Roentgen examination of the multiple sites of injury showed fractures of the left and right humeri and the left clavicle, and fractured dislocation of the left elbow joint with a fracture of the olecranon process. There were multiple abraded and contused wounds of the upper part of both legs and an injury to the previously stabilized left ankle joint, which radiologically gave no evidence of fracture.

Approximately four hours after admission she was operated upon, and the fractured left olecranon process and the left humerus were treated by intramedullary pin fixation. The right humerus was openly reduced and plated. The postoperative course was uneventful. She has been followed over a period of a year. Bony union of all of the fractures has been obtained, and the only disability at the present time is approximately 10 per cent disability due to weakness of the right shoulder and 25 per cent disability in the right wrist and hand secondary to inability completely to pronate and supinate the right forearm.

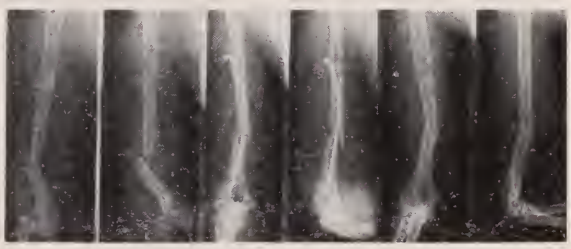


Fig. 6. — Illustrates the position of the original fracture fragments and the course followed to complete healing.

This case is presented chiefly to illustrate what not to do. In the pinning of the olecranon process after reduction of the fracture dislocation, an effort was made to drive a pin through the olecranon process after a drill hole was placed through the outer cortex of the bone. This resulted in splitting of the olecranon. It should be recalled that the medullary canal does not extend through the olecranon, and to apply intramedullary fixation satisfactorily a drill hole should be made completely through the olecranon process into the medullary canal of the ulna. The basic advantage of intramedullary pinning is that muscle pull is used to approximate the fracture fragments. The converse is true as regards the olecranon process in that muscle pull from the triceps is upward and tends to separate the fracture line. It is believed, therefore, that some type of additional fixation should be used to hold the fracture fragments of the olecranon process in apposition. This could be either

in the form of a circular wire through the fracture fragments or screw fixation. The intramedullary pin was started at about the junction of the upper and middle third of the humerus instead of near the tuberosity. Figure 6 shows what happens when this is done. The three point pressure is such that it results in a bowing at the fracture site resulting in a displacement of fragments. Also the pin used in this case was too small and too short for proper fixation of the humerus. In spite of all of these inefficiencies, the fractures went on to solid bony union with only a minor deformity at the fracture site.

Case 7. — Mr. D. W. H., a 31 year old, white, married logger, was hospitalized on May 2, 1951, approximately three hours after sustaining an injury to the right forearm while unloading a truck of logs. In the process of unloading the logs, a piece of metal was struck by a log, causing the metal bar to strike him across the midportion of the right forearm. On his arrival at the hospital there was a diffuse swelling and obvious deformity in the middle third of the right forearm. Motion in the hand was normal, and pulsation at the wrist was present and of good quality. There were no sensory changes distal to the area of injury. Roentgen studies revealed a both bone fracture of the right forearm.

Approximately 12 hours after admission, he was operated upon, and with employment of the technic described, intramedullary fixation of the fractured radius and ulna was performed. The postoperative course was entirely uneventful except for the diffuse swelling in the operated extremity. The fracture progressed to solid bony union without muscle atrophy, and he has been at work since four weeks following the injury. No type of cast support was used on the injured arm. Figure 7 shows the original and final positions of the fracture fragments.

Fig. 7. — The original position of fracture fragments and their immediate postoperative position.

The case illustrates an ideal method of treatment of both bone fractures of the forearm with correct application of the intramedullary nail. The comminuted fracture fragments could have been fixed in position by encircling wire, but this procedure was not considered necessary at the time of operation since they were in good position. The only postoperative complication was that of diffuse swelling in the operated extremity. This has occurred in a large percentage of our cases, and the etiology cannot be explained by us. The typical deformity of wide separation of fracture fragments and the tendency for the distal fragments to approximate each other are well illustrated.

Case 8. — Mrs. A. R. P., a 27 year old, white housewife was hospitalized on Dec. 26, 1950 after a home accident in which she slipped and fell on the floor, landing on her left hand and outstretched left forearm. There was diffuse swelling in the left forearm, and roentgen examination demonstrated a both bone fracture in the middle third of the radius and ulna in the injured extremity.

Approximately four hours after hospitalization, she was operated upon. The radius was reduced, and a Rush intramedullary nail was put in place. The fracture in the ulna was then exposed and reduced, and it was thought that fixation of this fracture would not be necessary since the radius had been stabilized. No cast was applied to the injured extremity. The fractures have progressed to solid bony union in both bones without any displacement of the reduced but nonstabilized ulna. Figure 8 shows the original and final positions of the fracture fragments.

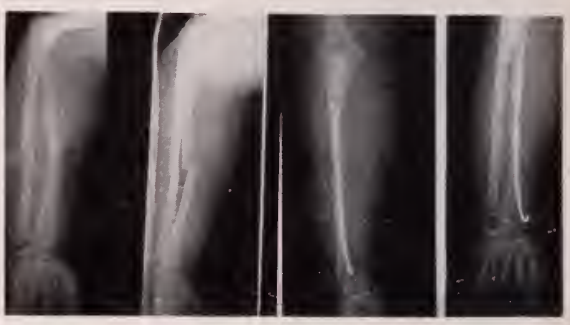


Fig. 8. — Original position of fracture fragments. The immediate postoperative position of these fragments after fixation of the radius and the reduction of the ulna.

This type of treatment is not routinely followed, but illustrates a well known principle. When one bone of a both bone forearm fracture is reduced and stabilized, the second bone can be reduced and will usually remain in a position of reduction.

Case 9. — G. H., a 55 year old, married, Negro logger, was hospitalized on Jan. 19, 1950 following an accident in which the right forearm was injured by a direct force when struck by a large moving log. He arrived at the hospital at approximately 12 o'clock noon, and on examination a diffuse swelling and an obvious deformity were noted in the midportion of the right forearm. Roentgen examination demonstrated a both bone fracture of the right forearm with great displacement of the fracture fragments. His general condition was good. Approximately two hours after admission, he was operated upon, and Rush intramedullary nails were put in place with excellent reduction and fixation of the fracture fragments (fig. 9). He was discharged from the hospital in eight days without any type of external support to the injured extremity.

The bones rapidly united in spite of a severe lymphedema type of swelling in the operated extremity. The edema resulted in a disability of eight weeks' duration.

Again, we direct attention to the unexplained postoperative complication of swelling of the extremity in which long bones have been fixed by intramedullary fixation.

Fig. 9. — The original position of the fracture fragments and their immediate postoperative position.

Case 10. — J. B. D., a 32 year old, married, Negro logger, was hospitalized for the first time on Nov. 16, 1950, approximately one hour after sustaining an injury to the right lower leg when the injured extremity was caught between a falling limb and the trunk of a tree. Roentgen examination revealed a comminuted fracture of the tibia and fibula at the junction of the lower and middle third.

Approximately two hours after admission, the fracture in the tibia was stabilized. A Rush intramedullary nail of 3/16 inch diameter was employed, and the technic described was used (fig. 10). The postoperative course was complicated by the swelling of the extremity, an occurrence so often mentioned in this discussion.

During the follow-up period, the swelling persisted in this extremity and a large amount of callus formed at the fracture site, which produced a tumor-like area easily palpated through the skin but caused the patient no difficulty. He followed routine postoperative instructions and was returned to work in approximately four weeks in spite of the swelling and excess callous formation at the fracture site.

Fig. 10. — Position of fracture fragments when first seen and the progress of the fracture until healed.

On review of the roentgenogram and the operative procedure, we now think that the intramedullary pin should have been longer, thereby more rigidly stabilizing the fracture. Because of this and another similar experience, we are of the opinion that a boot cast of plaster of paris for stabilization during a period of four weeks would promote better fracture fixation and results in the treating of fractures of the tibia. This opinion is based on multiple cases whose results were similar to the case reported. The contour of the medullary canal of the tibia is such that adequate stabilization at the fracture site cannot be expected through the use of single intramedullary procedures.

Case 11. — Mr. H. C. was hospitalized on Oct. 20, 1951 following an automobile accident in which he sustained fractures of the left humerus, left radius and ulna, and right femur, and also multiple rib fractures on the left side. He was in severe shock on admission to the hospital and was given 1,000 cc. of whole blood, oxygen, and sedation. He responded satisfactorily to this resuscitation therapy and on the next day was operated upon. Intramedullary fixation of the fractures in the femur, the humerus, and radius and ulna was performed in one session. Associated with the rib fracture was an atelectasis of the lower lobe of the left lung. The postoperative convalescence was completely uneventful, and the atelectasis rapidly cleared. He was discharged from the hospital on November 8.

Had this patient been treated by conventional methods, it would hardly have been possible to get into his room because of all the frames and traction apparatus used. Through the use of intramedullary fixation, none of these gadgets was necessary, and the postoperative care resolved itself into the care of multiple soft tissue wounds. The fracture fixation also permitted early ambulation, which indirectly resulted in the rapid clearing of the atelectasis of the lower lobe of the left lung. Figure 11 illustrates the position of the fracture fragments at the time of admission to the hospital, immediately after fracture fixation, and approximately two months after the operative procedures were performed. This case demonstrates one of the principle advantages of this method of fracture treatment as applied to a patient with many major injuries.

Fig. 11A.—Position of fracture fragments of the radius and ulna when first seen, again immediately postoperative, and during the course of healing.

Fig. 11B.—Original position of the fracture fragments of the femur, again immediately postoperative, and during the course of healing.

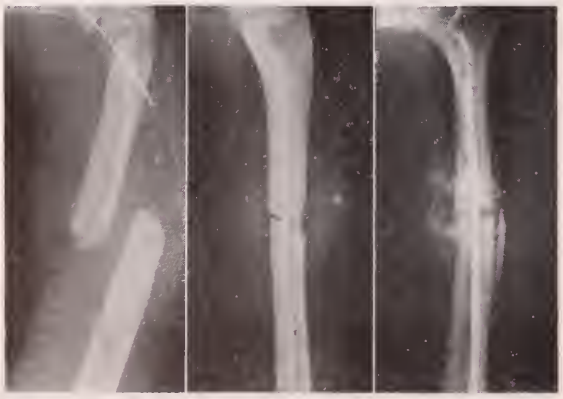


Fig. 11C.—Position of the fracture fragments of humerus when first seen, again immediately postoperative, and during its course of healing.

Summary

The principles, technics, and some of the complications of intramedullary fixation of fractures of long bones by using the Rush nail are presented. Cases illustrating the principles of fracture fixation and some of the hazards encountered in the use of the method are also presented.

References

Böhler, J.: Results in Medullary Nailing of Ninety-Five Fresh Fractures of the Femur, J. Bone & Joint Surg. 33-A:670-678 (July) 1951.

Böhler, L., and Böhler, J.: Küntscher's Medullary Nailing, J. Bone & Joint Surg. 31-A:295-305 (April) 1949.

Dickinson, J. A.: Intramedullary Fixation of Certain Fractures of Both Bones of Forearm; Report of 2 Cases, Cleveland Clin. Quart. 11:62-66 (July) 1944.

Fisher, A. W., und Maatz, R.: Weitere Erfahrungen mit der Marknagelung nach Küntscher, Arch. f. klin. Chir. 203:531-565, 1942.

Fitts, W. T., Jr.; Roberts, B.; Spoont, S. I., and Ritter, V. W.: Effect of Intramedullary Nailing on Healing of Fractures, Surg., Gynec. & Obst. 89:609-615 (Nov.) 1949.

Fowler, S. B., and Riordan, D. C.: Internal Fixation of Femur with the Küntscher Intramedullary Nail, South. M. J. 42:545-551 (July) 1949.

Groves, E. W. H.: Bone Transplantation, Brit. J. Surg. 5:185-242 (Oct.) 1917.

Groves, E. W. H.: Treatment of Ununited Fractures, Brit. J. Surg. 6:203-247 (Oct.) 1918.

Hedri, E.: Results with Medullary Nailing of Fractures of Femur, J. Internat. Coll. Surgeons 11:191-193 (March-April) 1948.

König, F.: Uber die Implantation von Elfenbein zum Ersatz von Knochen und Gelenken, Beitr. z. klin. Chir. 85:91-114, 1913.

Küntscher, G.: Die Marknagelung von Knochenbrüchen, Arch. f. klin. Chir. 200:443-455, 1940.

Lambotte, Albin: Chirurgie operatoire des fractures, Paris, Masson et Cie, 1913.

Lamhrinudi, C.: Intramedullary Kirschner Wires in Treatment of Fractures, Proc. Roy. Soc. Med. 33:153-157 (Jan.) 1940.

McLaughlin, H. L.; Gaston, S. R.; Neer, C. S., and Craig, F. S.: Open Reduction and Internal Fixation of Fractures of the Long Bones, J. Bone & Joint Surg. 31:94-101 (Jan.) 1949.

Merle D'Aubigne, R.: Surgical Treatment of Non-Union of Long Bones, J. Bone & Joint Surg. 31-A:256-266 (April) 1949.

Murray, G.: Method of Fixation for Fracture of Clavicle, J. Bone & Joint Surg. 22:616-620 (July) 1940.

Rush, L. V., and Rush, H. L.: Reconstruction Operation for Comminuted Fracture of Upper Third of Ulna, Am. J. Surg. 38:332-333 (Nov.) 1937.

Rush, L. V., and Rush, H. L.: Technique for Longitudinal Pin Fixation of Certain Fractures of Ulna and of Femur, J. Bone & Joint Surg. 21:619-626 (July) 1939.

Soeur, R.: Intramedullary Pinning of Diaphyseal Fractures, J. Bone & Joint Surg. 28:309-331 (April) 1946.

Speed, J. S., and Smith, H.: Campbell's Operative Orthopedics, St. Louis, C. V. Mosby Company, 1949, pp. 367-371.

Street, D. M.: One Hundred Fractures of the Femur Treated by Means of the Diamond-Shaped Medullary Nail, J. Bone & Joint Surg. 33:659-678 (July) 1951.

Street, D. M.; Hansen, H. H., and Brewer, B. J.: Medullary Nail; Presentation of New Type and Report of Case, Arch. Surg. 55:423-432 (Oct.) 1947.

Stuck, W. G., and Grebe, A. A.: Complications of Treatment of Fractures of Shaft of Femur, South. Surgeon 14:735-754 (Nov.) 1948.

Stuck, W. G., and Thompson, M. S.: Complications of Intramedullary Fixation of Fractures of the Femur, Arch. Surg. 63:675-686 (Nov.) 1951.

Tordoir, B. M., and Moeys, E. J.: Treatment of Certain Types of Fractures, with V2A Steel Nail in Medullary Cavity (Küntscher Method), J. A. M. A. 128:792-794 (July 14) 1945.

Westerborn, A.: Marrow-Nailing of Recent Fractures, Pseudarthrosis and Bone Plastic; Experiences in 100 Cases, Ann. Surg. 127:577-591 (April) 1948.

Frasier-Ellis Hospital.

814 South St. Andrews Street.

ABSTRACTS OF MEDICAL ARTICLES

A County Cares for Its Psychotics. By Sullivan G. Bedell, M.D. South. M. J. 45:222-224 (March) 1952.

Dr. Bedell describes, in his chairman's address before the Section on Neurology and Psychiatry of the Southern Medical Association, the steps taken by Duval County, consisting of Jacksonville and its environs with a population of 304,029, to care for its psychotic patients. It was customary for patients committed to the state hospital to await transfer in the county jail, sometimes for months because of the crowded conditions in the state hospital. In 1948, 100 mental patients spent a total of 1,504 days in jail awaiting transfer.

In 1945 the state legislature acted to provide a psychiatric unit as part of the Duval County Hospital, which is operated by the County Welfare Board. A one mill tax levy on real and personal property in 1946 and 1947, augmented by a federal grant of $109,595.51, yielded a total of $506,164.69. In January 1949 a modern 40-bed psychiatric hospital was ready for patients.

The custom of volunteer medical care has been carried on in the operation of this unit. Indigent patients have been cared for by the local psychiatrists on a volunteer basis. Pay patients are charged on a fee basis on an individual patient-physician relationship. Approximately one third of the patients have been pay or part pay patients and two thirds have been indigent. Almost from the opening day the unit has been filled with a list of patients awaiting admission.

During the first two years of operation, of 981 admissions, 790 of them white, 695 were classed as psychotic; the average hospital stay was 30 days; and 290 new patients attended the out-patient clinic, where 2,055 out-patient visits were made. The service has been accredited for one year residency training, and in 1951, for the first time, the staff of 12 interns rotated through psychiatry, one each month.

A unique feature is that by law the county judge can no longer place a committed patient in the county jail. If the state hospital has no bed available and he cannot be managed at home, the unit must accept him whether there is an empty bed or not. In this way state charges have the benefit of study and treatment prior to transfer, even though others on the list wait longer and longer. Approximately 35 per cent recover in the interim and return home without having to be admitted to the state hospital.

The psychiatric unit was brought into being as a result of broad community effort. To the state hospital, it means a reduction of admissions. To the individual patient and his family, its meaning is manifold. To the community, it means men and women returned to earning capacity, to citizenship, and to the status of fellow taxpayers.

Psychosomatic Aspects of Multiple Sclerosis. By Harry A. Teitelbaum, M.D., Ph.D., Bernard H. Hall, M.D., and Roger E. Phillips, M.D. Arch. Neurol. & Psychiat. 67:535-544 (April) 1952.

The authors review the dynamics of the holistic concept of personality as an organism-environment system previously elaborated by Teitelbaum as an integrative process of the cerebral cortex. They conclude that in traumatic situations, either psychogenic or organic, the normal cortical integrative processes may undergo disintegration and reintegration on a lower level, with a more limited range of adjustment of the organism within its environment. The process of cortical disintegration and reintegration is considered as the physiologic phase of the mechanism, of which the psychoanalytic process of regression is the psychologic phase.

The previous literature is reviewed to show how the various problems related to the psychosomatic aspects of multiple sclerosis have been considered in the past.

Four cases of multiple sclerosis are presented, and their psychosomatic aspects are discussed in the light of the holistic principles expressed in the introductory paragraphs.

Role of Protective Urinary Colloids in Prevention of Renal Lithiasis. By Arthur J. Butt. J. Urol. 67:450-459 (April) 1952.

The author defines a urinary calculus as a concretion formed of urinary crystalloids bound together by and incorporated in a colloidal matrix. He focuses his efforts to control calculous formation upon preventing the precipitation of colloids and thus indirectly diminishing the formation of urinary deposits rather than upon the usual method of trying to diminish the concentration of crystalloids excreted in the urine. After discussing in some detail the role of protective urinary colloids in the prevention of renal lithiasis, he presents the results of a study of a series of 185 cases of renal calculi.

Dr. Butt observes that a clearer understanding of urinary colloids helps explain in more basic physiochemical terms why adequate hydration is exceedingly important in the prevention and treatment of urinary calculi and he thinks that a better knowledge of the colloids may lead to a method of detecting which persons have a greater or lesser predisposition to the formation of urinary calculi. He reports elevated colloidal activity in the Negro race, which appears less liable to stone formation than the white race. Also, elevated colloidal activity in pregnant women may explain why pregnancy is not more frequently complicated by urinary calculi and why nulliparous women are relatively less prone to calculous formation than their parous sisters.

Since patients harboring renal calculi have decreased urinary colloids, the conclusion seems warranted that reduction or absence of these protective colloids has a definite bearing on the formation of stones in these patients.

Following injection of hyaluronidase in various groups of patients, there was a significant increase of colloidal activity in 82 per cent of the subjects. This response was greatest in Negroes, less in white persons without stones, and least in patients harboring renal calculi. An observation of particular interest was that specimens of urine from patients who had received hyaluronidase did not sediment for long periods of time as compared to specimens from the same subjects before they had received hyaluronidase.

Fractures of the Facial Bones — Standardization of Diagnosis and Treatment. By Carl S. McLemore, M.D. Ann. Otol., Rhin. & Laryng. 61:242-265 (March) 1952.

In this comprehensive study, the author points out the need for standardization of the diagnosis and treatment of fractures of the facial bones in view of the innumerable individual methods and appliances for reducing and immobilizing these fractures and the increase in their incidence during the present century. He notes that the incidence of fractures of individual bones varies considerably in series reported by civilian physicians, but is uniform in series reported in World Wars I and II.

Since there is difference of opinion as to what constitutes the facial bones, he offers a classification. Also, he suggests that the term zygoma replace the term malar bone and the term zygopalatine-maxillary bone be used to designate the maxilla, palatine bone and zygoma.

In diagnosis, complete reliance should not be placed on roentgen studies alone. To facilitate both correct diagnosis and appropriate treatment, there is no substitute for a concise knowledge of the anatomy of the bones involved. Of great aid also is a knowledge of the dynamics of fractures of these bones. With a view to standardization of diagnostic technic, Dr. McLemore outlines the important diagnostic procedures.

Presenting a series of 147 cases in this successful candidate's thesis submitted to the American Laryngological, Rhinological and Otological Society, he discusses certain fundamental principles of treatment which can be standardized. He describes a policy of adequate anesthesia and preparation for a general anesthetic, if necessary, and regards the Caldwell-Luc approach in any method of reducing fractures of the maxilla as practically mandatory. Also, consultation with an oral surgeon in all cases of fracture of the superior alveolar process or mandible and with a neurosurgeon in cases of fracture of the frontal bone is advisable in his opinion.

He describes his use of castex as a substitute for plaster in the making of head caps and his employment of a large orthopedic hook for use in reducing fractures of the arch of the zygoma. Commenting on the use of Kirschner wire, he presents an illustrative case.

Ileal Duplications. By Mark P. Fecher, M.D., Samuel M. Day, M.D., F. Gordon King, M.D. Ann. Surg. 135:555-559 (April) 1952.

The authors present 2 cases of ileal duplication, commonly called enteric or enterogenous cysts and generally occurring in infants and children. Symptoms are usually those of partial intestinal obstruction due to encroachment of adjacent intestine, but the principal symptom may be pain from distention of the cyst by large amounts of secreted fluid. Diagnosis is difficult, and treatment is surgical.

In the first of the 2 cases successfully treated, a boy aged 5 suffered recurrent symptoms of paroxysmal abdominal pain associated with paucity of physical, laboratory and roentgen findings. Palpation of a mass was not possible because of the soft cystic nature of the duplication. It was concluded that continued symptoms with only a single suggestive deformity demonstrated roentgenologically may justify surgical exploration.

The second case, occurring in an infant six weeks old, illustrates how a tubular duplication bent upon itself and occupying each side of the abdomen may simulate polycystic renal disease in an infant. A lateral roentgenogram was extremely helpful in making the diagnosis, which was confirmed at operation. The infant tolerated the operation well.

It is concluded that resection of the duplication cysts with the associated ileum and mesentery, followed by primary end to end anastomosis of the remaining ileal ends, is the treatment of choice in such cases.

Results of Lobotomy in Mental Disorders. By James G. Lyerly, M.D. South M. J. 45:793-798 (Sept.) 1952.

Dr. Lyerly describes bilateral prefrontal lobotomy as the operation of choice for the relief of certain types of severe mental disorders when convulsive shock therapy fails, or is contraindicated. It is also effective for the relief of intractable pain with nervous and mental symptoms and drug addiction. Unilateral prefrontal lobotomy may be performed in the less severe and milder forms of mental disorder, especially in the young person, when the least change of personality is desired.

The chain of symptoms relieved by the operation is that associated with affective and emotional disorders, as depression, anxiety, fear, apprehension, agitation, suicidal tendency, violence, assaultiveness and impulsive behavior. Most of these symptoms occur in involutional melancholia, agitated depression, manic depressive psychosis, anxiety and compulsion neurosis, and in certain types of schizophrenia.

Complications of a permanent nature resulting from the operation are minimal in the majority of cases. With the proper selection of cases the operative risk should not be over 1 per cent. In the series of 182 cases reported here, this operation was performed in the first 133 without a fatality. In summarizing the results in this series it is noted that the greatly and moderately improved cases represented 73.6 per cent, a proportion which should be sufficient reason to justify the operation.

Intracranial Tumors with Extracranial Metastases. By N. William Winkelman, Jr., M.D., Chester Cassel, M.D., and Benno Schlesinger, M.D. J. Neuropath. & Exper. Neurol. 11:149-166 (April) 1952.

Observing that the occurrence of extracranial metastases from intracranial tumors has been doubted by some authors and considered merely a medical curiosity by others, the authors of this article find the infrequency of this phenomenon both striking and provocative in view of the relative frequency of malignant intracranial neoplasms in man. They review the literature on this subject critically and report a case in which a fibrosarcoma of meningeal origin metastasized to the lungs.

Finding in the literature but 9 probably valid cases, they conclude that intracranial tumors infrequently give rise to extracranial metastases. To this number they add their case of fibrous meningeal tumor of over three years' duration, with pulmonary metastases, and while they find the data suggestive in the other 18 cases reported in the literature, they do not find them conclusive as to the primary character of the intracranial lesion.

In their discussion of the factors responsible for the relative infrequency of this phenomenon they state that extracranial metastases probably occur by direct invasion of intracranial venous channels and are blood borne. They add that it is unlikely that surgical intervention plays a significant role in the production of metastases.

Lymphoblastomatosis. By Thomas F. Nelson, M.D. South. M. J. 45:451-452 (May) 1952.

The author reports a case of lymphoblastomatosis and discusses the lymphoblastoma, a type of

tumor known by various names which may occur in any part of the lymphatic system. This lesion, he observes, can be classified as benign or malignant in nature, and the objective findings are few and vague, there being no relationship to leukemia because all blood pictures are normal except for the anemia probably secondary to undetected chronic bleeding from the intact mucosa. He adds that deep roentgen therapy should be used even if surgery is not contemplated.

Subjective and Objective Criteria in the Diagnosis of Meningiomas of the Brain, with Remarks as to Mortality and Useful Survival. By Gilbert Horrax, M.D., and Richard E. Strain, M.D. Ann. Surg. 135:892-898 (June) 1952.

Although meningiomas, because of their benign nature and surgical accessibility, are among the most favorable of all intracranial new growths, in some instances the insidious onset and slow progression of symptoms are so misleading that delayed diagnosis permits the lesions to become so large that their removal is difficult and hazardous. For this reason, the incidence and duration of the initial symptoms have been studied by these authors and certain special diagnostic features reviewed to aid in the detection of such tumors at as early a stage as possible.

With regard to symptomatology and diagnostic measures, this study deals only with the first consecutive 115 patients in the series, but the entire group of 168 is utilized for mortality and survival statistics. Of 1,146 verified brain tumors recorded between the years 1933 and 1946 at the Lahey Clinic, the 168 meningiomas represented 14.6 per cent.

Headache, visual disturbance and convulsions were the most frequent initial symptoms, although localized or unilateral weakness, loss of the sense of smell, ataxia and other symptoms were mentioned.

The authors also report on their study of the value and usefulness of such diagnostic aids as roentgenograms of the skull, both with and without air injections.

The operative mortality for meningiomas of the brain in this series was 13.6 per cent, but during the five year period from 1942 to 1946 inclusive, this mortality was reduced to 7.9 per cent. Seventy-eight per cent of the patients surviving their operations have lived from five to 18 years and of the five year survivors, 85 per cent were living useful lives up to the time of their last report or until their death.

Intraperitoneal Escape of Barium Enema Fluid in Perforation of Sigmoid Colon. By Ivan Isaacs, M.D. J. A. M. A. 150:645-646 (Oct. 18) 1952.

The author reports 2 cases of perforation of the sigmoid colon in which there was a free escape of barium enema fluid into the peritoneal cavity and observes that such an occurrence is probably not as rare as would be indicated by the paucity of reported cases. He discusses the predisposing causes, the commonest of which, exclusive of injury, are diverticulitis, chronic ulcerative colitis and cancer. Reports of demonstration of colon perforations by means of barium enema are rather few and mostly concern subacute perforations with local fistulas or abscess cavities rather than contamination of the general peritoneal cavity.

The radiographic appearance of this complication is described, including a linear streak of density lateral to the sigmoid or descending colon, which may be the first diagnostic sign. If the radiologist is alert to the possibility and can recognize promptly the appearance of the free escape of barium fluid from the colon, this linear parietal streak may be a helpful sign in making it possible to limit the degree of insult by immediate termination of the enema and prompt laparotomy.

Antihistamines as Local Anesthetic Agents for Urethral Manipulation. By Raymond J. Fitzpatrick, M.D., Louis M. Orr, M.D., and F. James Stubbard, M.D. J. A. M. A. 150:1092-1094 (Nov. 15) 1952.

The results of clinical trial of a 2 per cent solution of tripelennamine (pyribenzamine®) hydrochloride as a local anesthetic agent in 100 cases is presented. The use of this drug for this purpose is not suggested as a substitute for all the various anesthetics that have been time-tested and proved of great value. Particularly, however, for the patient who demonstrates an idiosyncrasy to the usual agents, it is described as another drug now available which will produce excellent anesthesia and which is, of its very essence, antiallergic in nature. Also, its use in cases of active

bleeding is clearly indicated when a cystoscopy is a necessary part of the clinical examination. Solutions of tripelennamine are stable on standing and can be sterilized by boiling or autoclaving. If this use of solutions and of special pellets of pyribenzamine for installation into the posterior urethra becomes general, the authors observe, it is probable that they will be made available commercially; meanwhile, they can be obtained for clinical investigative purposes.

In future, the authors intend to have available at all times solution, ointment, and pellets of tripelennamine. They now are using these preparations exclusively for urethral anesthesia and whenever they may be indicated for patients who show sensitivity to the usual topical anesthetic drugs. The results of their extended investigation will be the subject of a future report.

Inhibition of the Clot-Accelerating Property of Ingested Fat by Simultaneous Feeding of Sugar. By Jerome M. Waldron, Barkley Beidleman and Garfield G. Duncan. J. Applied Physiol. 4:761-763 (March) 1952.

It has been demonstrated that the oral ingestion of fat in the form of olive oil, refined corn oil and cream from cow's milk increases the coagulability of the blood of dogs and man. Cream also exhibited in vitro clot-accelerating properties, and it was suggested that this local and systemic effect of cream on the process of coagulation may be an indication for its use in the control of gastrointestinal bleeding. In view of the definite change in blood coagulation produced by these common dietary fats, the authors studied the effects of proteins, carbohydrates and combinations of these three substances. This report concerns the interesting results obtained when carbohydrate was combined with fat.

Studies are presented on human subjects in which the increased coagulability of the blood after feeding fat in the form of cream or refined corn oil was compared to the changes induced by adding either sucrose or lactose to the fat. When the sugar was fed with the fat, the clotting time did not decrease as much as when the fat was fed alone. This was not due to any anticoagulant properties of the sugar because when sugar is fed alone, it has clot-accelerating properties.

Cystic Disease of the Lungs. By Francis N. Cooke, M.D., and Brian Blades, M.D. J. Thoracic Surg. 23:546-569 (June) 1952.

This study indicates that the incidence of cystic disease of the lungs occurs much more frequently than is indicated by figures based on routine roentgenogram or necropsy examinations. A classification of the various types of cysts is proposed; they are discussed under the two broad headings of congenital pulmonary cysts and acquired cystic disease of the lungs. Ten illustrative case reports are presented. There is comment on the confusion regarding nomenclature as well as classification, and it is observed that a standardization of the nomenclature would facilitate analyses and help clarify much of the confusion associated with prognosis and treatment. Some of the many problems occurring in the surgical management of cases of this type are discussed.

NOTICE

This May Journal carries the new officers and committeemen with the exception of the president-elect, vice presidents, secretary-treasurer and editor of The Journal. The names of these officers are omitted because the May Journal went to press before the election of officers by the House of Delegates, April 29.

All new officers will be listed in your June Journal, as will the personnel of The Journal staff for 1953.

FLORIDA MEDICAL ASSOCIATION

OFFICERS AND COMMITTEES

OFFICERS

FREDERICK K. HERPEL, M.D., President....*W. Palm Beach*

MANAGING DIRECTOR

STEWART G. THOMPSON, D.P.H.....*Jacksonville*
ERNEST R. GIBSON, Assistant.....*Jacksonville*

BOARD OF GOVERNORS*

FREDERICK K. HERPEL, M.D., Chm...(Ex Officio)..*W.P.B.*
EDWARD JELKS, M.D...AL-54.....*Jacksonville*
JAMES H. POUND, M.D...A-54.....*Tallahassee*
NORVAL M. MARR, M.D...C-55.....*St. Petersburg*
JOHN D. MILTON, M.D...D-56.....*Miami*
MEREDITH MALLORY, SR., M.D...B-57.....*Orlando*
DAVID R. MURPHEY, JR., M.D...PP-54.....*Tampa*
ROBERT B. McIVER, M.D...PP-55.....*Jacksonville*

HERBERT L. BRYANS, M.D...S.B.H.-54.....*Pensacola*
STEWART G. THOMPSON, D.P.H. (Advisory)..*Jacksonville*

*SUB-COMMITTEES

1. Veterans Care

FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
GEORGE M. STUBBS, M.D.....*Jacksonville*
DOUGLAS D. MARTIN, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

2. Advisory to National Foundation Infantile Paralysis

FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
H. PHILLIP HAMPTON, M.D.....*Tampa*
ROBERT P. KEISER, M.D.....*Coral Gables*
RICHARD G. SKINNER, JR., M.D.....*Jacksonville*

3. Review of Fee Schedules

JOHN D. MILTON, M.D., Chm.....*Miami*
WOODROW B. ESTES, M.D.....*St. Petersburg*
FREDERICK H. BOWEN, M.D.....*Jacksonville*
ODIS G. KENDRICK, JR., M.D.....*Tallahassee*
JAMES B. GLANTON, M.D.....*Orlando*
FLOYD K. HURT, M.D.....*Jacksonville*
HERSCHEL G. COLE, M.D.....*Tampa*
A. FRANKLIN HARRISON, M.D.....*Madison*
JACK O. W. RASH, M.D.....*Miami*
KENNETH S. WHITMER, M.D.....*Miami*
ADELBERT F. SCHIRMER, M.D.....*Orlando*

4. Blue Shield

LEIGH F. ROBINSON, M.D., Chm.....*Ft. Lauderdale*

SCIENTIFIC WORK

JERE W. ANNIS, M.D., Chm...C-55.....*Lakeland*
SIDNEY DAVIDSON, M.D...AL-54.....*Lake Worth*
FREDERICK K. HERPEL, M.D...D-54.....*W. Palm Beach*
RICHARD C. CUMMING, M.D...B-56.....*Ocala*
ARTHUR J. BUTT, M.D...A-57.....*Pensacola*

LEGISLATION AND PUBLIC POLICY

H. PHILLIP HAMPTON, M.D., Chm...AL-54.....*Tampa*
A. JUDSON GRAVES, M.D...B-54.....*Jacksonville*
ANGUS D. GRACE, M.D...C-55.....*Fort Myers*
DONALD W. SMITH, M.D...D-56.....*Miami*
GEORGE H. GARMANY, M.D...A-57.....*Tallahassee*
FREDERICK K. HERPEL, M.D. (Ex Officio) *W. Palm Beach*

MEDICAL EDUCATION AND HOSPITALS*

JACK Q. CLEVELAND, M.D., Chm...AL-54....*Coral Gables*
ELBERT McLAURY, M.D...D-54.....*Hollywood*
S. CARNES HARVARD, M.D...C-55.....*Brooksville*
BENJAMIN F. DICKENS, M.D...B-56.....*Fernandina*
JOSEPH W. DOUGLAS, M.D...A-57.....*Pensacola*

*SPECIAL ASSIGNMENT

1. Urge Gifts to American Medical Education Foundation

NECROLOGY

ALVIN L. STEBBINS, M.D., Chm...A-56.....*Pensacola*
DAVID A. NEWMAN, M.D...AL-54.....*Palm Beach*
WALLACE H. MITCHELL, M.D...D-54.....*Key West*
JOSEPH J. LOWENTHAL, M.D...B-55.....*Jacksonville*
HUGH G. REAVES, M.D...C-57.....*Sarasota*

MEDICAL POSTGRADUATE COURSE

TURNER Z. CASON, M.D., Chm...B-55.....*Jacksonville*
W. WELLINGTON GEORGE, M.D...AL-54....*W. Palm Beach*
J. BROWN FARRIOR, M.D...C-54.....*Tampa*
FRANCIS T. HOLLAND, M.D...A-56.....*Tallahassee*
JAMES C. ROBERTSON, M.D...D-57.....*Vero Beach*

CANCER CONTROL

FRAZIER J. PAYTON, M.D., Chm...D-54.....*Miami*
CHARLES McD. HARRIS, JR., M.D...AL-54..*W. Palm Beach*
GEORGE W. MORSE, M.D...A-55.....*Pensacola*
WESLEY W. WILSON, M.D...C-56.....*Tampa*
DOROTHY D. BRAME, M.D...B-57.....*Orlando*

MEDICAL ECONOMICS

REUBEN B. CHRISMAN, JR., M.D., Chm...AL-54....*Miami*
HARRISON A. WALKER, M.D...D-54.....*Miami*
WILLIAM H. WALTERS, JR., M.D...C-55.....*Lacoochee*
WILLIAM C. ROBERTS, M.D...A-56.....*Panama City*
J. MAXEY DELL, JR., M.D...B-57.....*Gainesville*

VENEREAL DISEASE CONTROL

MELVIN M. SIMMONS, M.D., Chm...C-55.....*Sarasota*
CLARENCE L. BRUMBACK, M.D...AL-54....*W. Palm Beach*
WILEY M. SAMS, M.D...D-54.....*Miami*
DAVID W. GODDARD, M.D...B-56.....*Daytona Beach*
C. W. SHACKELFORD, M.D...A-57.....*Panama City*

TUBERCULOSIS AND PUBLIC HEALTH*

PHILLIP W. HORN, M.D., Chm...B-57.....*Jacksonville*
RALPH M. OVERSTREET, JR., M.D...AL-54..*W. Palm Beach*
ERASMUS B. HARDEE, M.D...D-54.....*Vero Beach*
LOUIS J. GARCIA, M.D...C-55.....*Tampa*
HARRY S. HOWELL, M.D...A-56.....*Lake City*

*SPECIAL ASSIGNMENT

1. Diabetes Control

STATE CONTROLLED MEDICAL INSTITUTIONS

Samuel G. Hibbs, M.D., Chm...C-55.....*Tampa*
W. Lawson Shackelford, M.D...AL-54..*W. Palm Beach*
James G. Lyerly, M.D...B-54.....*Jacksonville*
William D. Rogers, M.D...A-56.....*Chattahoochee*
Edward H. Williams, M.D...D-57.....*Miami*

MATERNAL WELFARE

E. Frank McCall, M.D., Chm...B-56.....*Jacksonville*
James R. Sory, M.D...AL-54.....*W. Palm Beach*
John N. Sims, Sr., M.D...A-54.....*Live Oak*
Ralph W. Jack, M.D...D-55.....*Miami*
Oren A. Ellingson, M.D...C-57.....*Tampa*

CHILD HEALTH

Warren W. Quillian, M.D., Chm...D-54...*Coral Gables*
C. Jennings Derrick, M.D...AL-54.....*W. Palm Beach*
Daniel F. H. Murphey, M.D...C-55.....*St. Petersburg*
Courtland D. Whitaker, M.D...A-56.....*Marianna*
Ludo von Meysenbug, M.D...B-57.....*Daytona Beach*

CONSERVATION OF VISION

Sherman B. Forbes, M.D., Chm...C-54.....*Tampa*
Bascom H. Palmer, M.D...AL-54.....*Miami*
G. Tayloe Gwathmey, M.D...B-55.....*Orlando*
Mozart A. Lischkoff, M.D...A-56.....*Pensacola*
Younger A. Staton, M.D...D-57.....*W. Palm Beach*

ADVISORY TO WOMAN'S AUXILIARY

C. Robert DeArmas, M.D., Chm...B-55..*Daytona Beach*
L. Washington Dowlen, M.D...AL-54.....*Miami*
James L. Anderson, M.D...D-54.....*Miami*
Taylor W. Griffin, M.D...A-56.....*Quincy*
John S. Helms, Jr., M.D...C-57.....*Tampa*

REPRESENTATIVES TO INDUSTRIAL COUNCIL*

Fred H. Alree, Jr., M.D., Chm...AL-54.....*Orlando*
Chas. L. Farrington, M.D...C-54.....*St. Petersburg*
Charles R. Burbacher, M.D...D-55.....*Coral Gables*
Lee Sharp, M.D...A-56.....*Pensacola*
Frank L. Fort, M.D...B-57.....*Jacksonville*

*SPECIAL ASSIGNMENT

1. *Industrial Health*

COUNCILOR DISTRICTS AND COUNCIL

John D. Milton, M.D., Chm...AL-54.....*Miami*
First—Francis M. Watson, M.D...1-54.....*Marianna*
Second—George S. Palmer, M.D...2-55.....*Tallahassee*
Third—William C. Thomas, Jr., M.D...3-54..*Gainesville*
Fourth—Thomas C. Kenaston, M.D...4-55.....*Cocoa*
Fifth—Clyde O. Anderson, M.D...5-55...*St. Petersburg*
Sixth—Emmett E. Martin, M.D...6-54.....*Haines City*
Seventh—Erasmus B. Hardee, M.D...7-54....*Vero Beach*
Eighth—Russell B. Carson, M.D...8-55..*Ft. Lauderdale*

GRIEVANCE COMMITTEE

Walter C. Payne, M.D., Chm.....*Pensacola*
Robert B. McIver, M.D.....*Jacksonville*
David R. Murphey, Jr., M.D.....*Tampa*
Herbert E. White, M.D.....*St. Augustine*
Joseph S. Stewart, M.D.....*Miami*

ADVISORY TO SELECTIVE SERVICE FOR PHYSICIANS AND ALLIED SPECIALISTS

J. Rocher Chappell, M.D., Chm.....*Orlando*
Thomas H. Bates, M.D..."A".....*Lake City*
Frank L. Fort, M.D..."B".....*Jacksonville*
Alvin L. Mills, M.D..."C".....*St. Petersburg*
John D. Milton, M.D..."D".....*Miami*

EMERGENCY MEDICAL SERVICE

James B. Freeman, M.D., Chm.....*Jacksonville*
Merritt R. Clements, M.D..."A".....*Tallahassee*
Vernon A. Lockwood, M.D. "B".....*St. Augustine*
C. Frank Chunn, M.D..."C".....*Tampa*
C. Jennings Derrick, M.D..."D".....*W. Palm Beach*

A.M.A. HOUSE OF DELEGATES

Louis M. Orr, II, M.D., Delegate.....*Orlando*
Joshua C. Dickinson, M.D., Alternate.....*Tampa*
(Terms expire Dec. 31, 1953)
Reuben B. Chrisman, Jr., M.D., Delegate.....*Miami*
Frank D. Gray, M.D., Alternate.....*Orlando*
(Terms expire Dec. 31, 1954)
Herbert L. Bryans, M.D., Delegate.....*Pensacola*
Thomas H. Bates, M.D., Alternate.....*Lake City*
(Terms expire Dec. 31, 1954)

BOARD OF PAST PRESIDENTS

William E. Ross, M.D., 1919.....*Jacksonville*
H. Marshall Taylor, M.D., 1923.....*Jacksonville*
John C. Vinson, M.D., 1924.....*Fort Myers*
John S. McEwan, M.D., 1925.....*Orlando*
H. Mason Smith, M.D., 1926.....*Tampa*
John A. Simmons, M.D., 1927.....*Arcadia*
Frederick J. Waas, M.D., 1928.....*Jacksonville*
Julius C. Davis, M.D., 1930.....*Quincy*
William M. Rowlett, M.D., 1933.....*Tampa*
Homer L. Pearson, Jr., M.D., Chm., 1934.....*Miami*
Herbert L. Bryans, M.D., 1935.....*Pensacola*
Orion O. Feaster, M.D., 1936.....*Renton, Wash.*
Edward Jelks, M.D., 1937.....*Jacksonville*
Leigh F. Robinson, M.D., 1939.....*Fort Lauderdale*
Walter C. Jones, M.D., 1941.....*Miami*
Eugene G. Peek, Sr., M.D., 1943.....*Ocala*
John R. Boling, M.D., 1944, 1945.....*Tampa*
Shaler Richardson, M.D., 1946.....*Jacksonville*
William C. Thomas, Sr., M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne, M.D., 1949.....*Pensacola*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey, Jr., M.D., 1951.....*Tampa*
Robert B. McIver, M.D., Secy., 1952.....*Jacksonville*

The Journal of the Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION

P. O. BOX 1018 JACKSONVILLE, FLORIDA

Editor
Shaler Richardson, M.D.

Assistant Editors
Webster Merritt, M.D.
Franz H. Stewart, M.D.

Assaciate Editars

Louis M. Orr, II, M.D. ..... Orlanda
Joseph J. Lowenthal, M.D. ..... Jacksonville
Jere W. Annis, M.D. ..... Lakeland
Herschel G. Cale, M.D. ..... Tampa
Wilsan T. Sowder, M.D. ..... Jacksonville
Carlos P. Lamar, M.D. ..... Miami
Walter C. Poyne, M.D. ..... Pensacola

Managing Editar
Stewart G. Thompson, D.P.H.
Ernest R. Gibson, Asst.

Committee on Publication

Shaler Richardson, M.D., Chairman ..... Jacksanville
Chas. J. Callins, M.D. ..... Orlanda
James N. Pattersan, M.D. ..... Tampa

Abstract Department

Kenneth A. Marris, M.D., Chairman ..... Jacksanville
Walter C. Janes, M.D. ..... Miami

NOTICE

This May Journal carries the new officers and committeemen with the exception of the president-elect, vice presidents, secretary-treasurer and editor of The Journal. The names of these officers are omitted because the May Journal went to press before the election of officers by the House of Delegates, April 29.

All new officers will be listed in your June Journal, as will the personnel of The Journal staff for 1953.

Pediatric Trends and Changing Concepts

Half a century ago, it was largely by chance or inheritance that children grew weak or strong. Little was known about nutrition, the therapy of the period was rarely definitive, and prophylaxis was all but nonexistent. The family doctor seldom saw a child who was not seriously ill, and protracted illness required many visits to the home and not infrequently long night vigils. Some 600,000 children under 15 years of age succumbed annually from all causes, the death rate in 1900 being about 2,370 per 100,000.[1]

In 50 years, there has been a decrease of 92 per cent in deaths from all causes in children aged 1 through 4 years, and of 83 per cent in those aged 5 through 14. For the 12 principal infectious causes of death, the decrease has been 96 and 95 per cent respectively. In the former of these two groups, however, the mortality for the noninfectious causes of death, namely, congenital deformity and cancer, has increased by 95 per cent, and in the latter group by 236 per cent. As pointed out editorially in the New York State Journal of Medicine,[1] these figures call for a changing concept on the part of the practicing physician. Every effort must be made to improve his knowledge of the handling of cancer and the congenital malformations.

The apparent increase in deaths due to cancer, leukemia and Hodgkin's disease is no doubt "influenced by improved medical care with earlier and more accurate diagnosis, and the saving of about 750,000 children's lives annually in 1949 as compared to 1900." The fact that more children are living in this country each year may well alter the picture. Despite a reduction of 50 per cent in mortality during the first half of the century, it is to be remembered also that rheumatic fever and rheumatic heart disease take a toll of 5,000 deaths annually in the age group of 5 through 14 years. Too, accidents, by far the leading cause of death in children, take an increasingly disturbing toll.

These statistical trends are of moment to the physician today who treats children. Awareness of them should constantly remind him, especially the general practitioner and the pediatrician, of his supporting role in the education of his patient families regarding nutrition and available modali-

ties for improving the health of the child, both physically and emotionally; in supporting actively a program of periodic medical examination and evaluation of the apparently well child; in participating in the prophylactic immunization program; in cooperating with official and voluntary health services and school health programs; in promoting dental hygiene; in accident prevention; and in keeping himself well informed regarding available medical skills for correcting or ameliorating many of the congenital malformations.

These interests and duties are stressed now as they were not at the turn of the century. The pediatrician today spends over half of his time, it is estimated, in preventive medicine of various forms, public health procedures and education. The general practitioner is gradually becoming more and more aware of his opportunities in these fields. His increasing interest is encouraging, for from him at least 60 per cent of the children of this country receive all of their medical care. While he devotes one third of his practice to the care of children, he nevertheless directs but 30 per cent of this service to the field of health supervision and preventive medicine.[1]

The general practitioner and the pediatrician of the present day must find in the decreasing mortality and shortened period of illnesses among children not only deep satisfaction but also a spur to expand their knowledge and proficiency to conquer the problems which remain.

1. Pediatrics — Then and Now, New York State J. Med. 53:35-37 (Jan. 1) 1953.

Accident Toll in Children

In the many-sided role life metes out to the physician, the relative place of educator may be misjudged or overlooked. The general practitioner and the pediatrician have the special privilege of playing a large part in educating their children patients and their patient families. Especially is there opportunity to make parents aware of the dangers of accidental death for their children and specifically to instruct them in means to be employed in accident prevention.

The relative increase in accidental deaths among children as mortality from other causes is reduced is truly alarming. Numerically, accidents account for approximately 10,000 child deaths annually, or about one third of all the deaths from all causes. In children aged 1 through 4 years, accidental deaths in 1949 exceeded by 93 per cent the deaths from influenza and pneumonia, the second largest cause of death. That same year, in children aged 5 through 14, accidental deaths exceeded by 268 per cent the next largest cause of death, which was cancer. In 1951, motor vehicle accidents caused 39 per cent of accidental deaths, drowning 30 per cent, fire 9 per cent and various other accidents 22 per cent.[1]

Accident prevention, a relatively frequent topic in these columns, promises to be a perennially timely subject unless education and increased safeguards are better able than in the past to accomplish some reduction in the accidental death rate. It is estimated that in the next decade the school age population in the nation will increase by more than 33 per cent. With this increase, the mortality rate in this age group will inevitably climb proportionately unless physicians, educators, law enforcement officials and the community at large join with parents in strenuous preventive efforts.

1. Pediatrics — Then and Now, New York State J. Med. 53:35-37 (Jan. 1) 1953.

All That Paper Work

No wonder physicians often wonder why they continually face so much paper work. To find at least a partial answer, they have only to ask the Commission on Financing of Hospital Care. In its first progress report, this nongovernmental agency in February gave an account of a study of what is called "Third-Party Payments for Hospital Care." Those agencies which pay the hospital for services on behalf of a patient are the third parties constituting the subject of this report. And how many "third party" agencies are there? At least 20,000. Just imagine the paper work from that source alone.

Another interesting item in the commission's report was: "In the five years between 1946 and 1951, the cost to hospitals for each day of patient care rose from a national average of $9.39 to $16.77 — an increase of 79 per cent. How much of the increased cost of hospitalization is due to expanded services; how much to higher costs of labor and materials? That is a question for the commission to answer. By what means may costs be held to a minimum, through more efficient management, without impairing services? That is another item for the commission agenda."

Future progress reports of this agency should be of general interest.

A Woman's World?

Had you noticed that ours is becoming more and more a woman's world? There are now statistics to substantiate this impression. When women remark upon the scarcity of men, their reasons for this observation may be anything but scientific. Nevertheless, they speak better than they know perhaps, for the basic fact is true. Furthermore, this dearth of the male of the species promises to increase.

For the first time in American history, there are more women than men in our nation's population. In fact, there are nearly a million and a half more, as revealed by the 1950 census, and "according to present indications, the preponderance of women will continue to grow, with attendant increase in widowhood and dependency."[1] In the age groups over 45 years, according to the census, women outnumber men 1,000 to 956. With advance in age the difference increases rapidly, reaching 855 men per 1,000 women at ages 70 and over.

Chief among the various factors contributing to the growing predominance of women over men is the higher death rate of males. The ratio of deaths in males to deaths in females had increased from 1,210 deaths in males per 1,000 deaths in females in 1930 to 1,333 in males per 1,000 in females by 1951.

Another contributing factor is the changing sex pattern of migration. In recent years, immigrants to this country have been predominantly women, many of them war brides and fiancées of American service men, and more men than women have been leaving the country. In the five years immediately following World War II, a net gain of 181,500 women over men occurred by migration. In addition, war deaths have widened the margin between the male and female populations. But for losses sustained in World War II, the present excess of American women over men would be reduced by about a third of a million.

Since these contributing factors are continuing, it appears that the excess of women will become even larger in the future. The prospect of a woman's world seems, therefore, to be good. Nevertheless, like some of our editorial colleagues, we are not among those who might be appalled at this prospect. "If there are to be more women than men in the population," comments one editor, "let them be busy about the nation's business."[2] Far from dismayed, another comments: "In these days of intense political awareness it can be but a short time before the women of the land discover in whose hands the power lies. With a clear distaff majority at the polls, an enlightened matriarchate may well supersede the possibly impending welfare state."[3]

After all, who among men of medicine would not prefer Mrs. Oveta Culp Hobby to one Oscar Ewing?

1. Numerical Predominance of Women over Men in the United States, J. A. M. A. 150:1222-1223 (Nov. 22) 1952.
2. Of This and That, New York State J. Med. 53:156 (Jan. 15) 1953.
3. Amazonia, New England J. Med. 247:863 (Nov. 27) 1952.

Lecturers for Twenty-First Annual Graduate Short Course for Doctors of Medicine

June 22-27, 1953
Jacksonville
George Washington Hotel

Medicine: Dr. Thomas M. Durant — Professor of Clinical Medicine, Temple University School of Medicine; Visiting Physician, Philadelphia General Hospital; Consultant in Internal Medicine, U. S. Naval Hospital, Philadelphia; Member of Examining Board, American Board of Internal Medicine; Member of Board of Directors, American Heart Association.

Pediatrics: Dr. Robert E. Cooke — Assistant Professor of Pediatrics and Physiology, Yale University School of Medicine; a John and Mary R. Markle Scholar; New Haven, Conn.

Obstetrics: Dr. M. Edward Davis — The Joseph Bolivar DeLee Professor of Obstetrics and Gynecology, University of Chicago and the Chicago Lying-In Hospital, Chicago.

Surgery: Dr. Kenneth W. Warren — Member of Staff of Lahey Clinic, New England Baptist Hospital, New England Deaconess Hospital; Boston.

Gynecology: Dr. Conrad G. Collins — Professor and Chairman, Department of Obstetrics and Gynecology, Tulane University of Louisiana School of Medicine; Senior Visiting Surgeon and Obstetrician and Gynecologist-in-Chief Tulane Unit, Charity Hospital of Louisiana at New Orleans; Senior Consultant in Obstetrics and Gynecology, U. S. Public Health Hospital; Senior Consultant Sara Mayo Hospital; Member of American Board of Obstetrics and Gynecology; New Orleans.

Diseases of the Chest: Dr. J. L. Wilson — Director of Clinics, The Henry Phipps Institute, The University of Pennsylvania, Philadelphia.

SCHEDULE FOR SHORT COURSE

HOUR	Monday June 22	Tuesday June 23	Wednesday June 24	Thursday June 25	Friday June 26	Saturday June 27
8:00	**Registration**					
9:00	**Medicine** "Methods of Examination of the Cardiac Patient and the Importance of Etiologic Diagnosis" Dr. Durant	**Medicine** "Congestive Failure: Pathophysiology and Therapy" Dr. Durant	**Obstetrics** "Obstetrical Factors in Perinatal Mortality" Dr. Davis	**Diseases of the Chest** "Ambulant Chemotherapy of Tuberculosis: Its Place and Practice Today" Dr. Wilson	**Gynecology** "Pelvic Infection" Dr. Collins	**Gynecology** "Uterine Prolapse" Dr. Collins
10:00	**Pediatrics** "Fluid Therapy in Children" Dr. Cooke	**Obstetrics** "The Management of the Placental Stage and Postpartum Hemorrhage" Dr. Davis	**Medicine** "The Etiology of Coronary Atherosclerosis" Dr. Durant	**Gynecology** "Ectopic Pregnancy" Dr. Collins	**Diseases of the Chest** "Obstructive Emphysema — Physiologic Pathology and Treatment" Dr. Wilson	**Surgery** "Lesions of the Biliary Tract" Dr. Warren
11:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**	**Gynecology** "Embolism in Obstetrics and Suppurative Pelvic Thrombophlebitis" Dr. Collins
11:30	**Obstetrics** "The Modern Role of Abdominal Delivery" Dr. Davis	**Pediatrics** "Modern Treatment of Nephrosis" Dr. Cooke	**Pediatrics** "Care of the Premature" Dr. Cooke	**Surgery** "The Peptic Ulcer Problem" Dr. Warren	**Surgery** "Inflammatory Lesions of the Pancreas" Dr. Warren	**Surgery** "Inflammatory Lesions of the Small and Large Intestines" Dr. Warren
12:30	**Lunch**	**Lunch**	**Lunch**	**Lunch**	**Lunch**	
2:00	**Pediatrics** "Fluid Therapy in Children" — Cont. Dr. Cooke	**Medicine** "Rheumatic Heart Disease" Dr. Durant	**Obstetrics** "The Study of the Sterile Couple" Dr. Davis	**Diseases of the Chest** "Collapse Therapy of Tuberculosis; Relations to Surgical Treatment and Indications" Dr. Wilson	**Diseases of the Chest** "Differential Diagnosis of Chronic Pulmonary Diseases" Dr. Wilson	
3:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**	
3:15	**Medicine** "The Cardiac Arrhythmias" Dr. Durant	**Obstetrics** "Trends in the Management of Placenta Previa at the Chicago Lying-In Hospital" Dr. Davis	**Medicine** "The Management of Coronary Disease" Dr. Durant	**Gynecology** "Malignant Disease of the Uterus" Dr. Collins	**Surgery** "Pancreatic Tumors and Carcinoma of the Stomach" Dr. Warren	
4:15	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**	
4:30	**Obstetrics** "The Hormonal Factor in Abortions" Dr. Davis	**Pediatrics** "Celiac Syndrome" Dr. Cooke	**Pediatrics** "Diagnosis and Treatment of Erythroblastosis Fetalis" Dr. Cooke	**Surgery** "The Thyroid Adenoma and Malignant Disease of the Thyroid" Dr. Warren	**Gynecology** "Cervical Stump" Dr. Collins	
5:30	Cocktail Party George Washington Hotel			Boat Ride on St. Johns River, Compliments of George Washington Hotel		

Schedule for First Annual Meeting of The Florida Clinical Diabetes Association

Suwannee Hotel, St. Petersburg
May 14-15, 1953

FACULTY

Dr. F. B. Peck, Director, Medical Division, The Lilly Research Laboratories, Eli Lilly and Company, Indianapolis.

Dr. Howard Root, Associate in Medicine, Harvard Medical School; member Administrative Staff, New England Deaconess Hospital, Boston.

Dr. Sidney Davidson, Lake Worth.

Dr. Carlos P. Lamar, Miami.

Dr. Edward R. Smith, Director, Division of Nutrition and Diabetes Control, Florida State Board of Health, Jacksonville.

SCHEDULE

THURSDAY, MAY 14

Moderator — Dr. Everett M. Harrison, President Pinellas County Medical Society

8:30	Registration
9:15-10:15	Diabetes — Its General Management. Dr. Peck
10:15-11:15	Diabetic Ketosis, Treatment and Prevention. Dr. Root
11:15-11:30	Recess
11:30-12:15	Control of Diabetes. Dr. Root

Moderator — Dr. Clyde O. Anderson

2:00- 2:30	New Views on Pathology of Diabetes. Dr. Root
2:30- 3:00	Diagnostic Measures and Problems. Dr. Peck
3:00- 3:15	Recess
3:15- 4:15	Surgery and Lesions of the Extremities. Dr. Root
4:15- 4:45	Diabetic Neuropathy. Dr. Davidson
4:45- 5:15	Medical Profession, Public Education and Preventive Measures. Dr. Peck.
6:30	Dinner Meeting of Association — Lakewood Country Club

FRIDAY, MAY 15

Moderator — President of the Association

9:00- 9:30	The Various Insulins and Their Use. Dr. Peck
9:30-10:15	Diabetic Triopathy. Dr. Root
10:15-10:30	Recess
10:30-11:15	Hypoglycemia. Dr. Peck
11:15-11:45	Transient Acute Insulin Resistance. Dr. Lamar
11:45-12:15	Cardiovascular Complications. Dr. Root

Moderator — Dr. C. K. Donegan

2:00- 2:30	Childhood and Youth. Dr. Root
2:30- 3:30	Problems in Treatment of Infections and Other Complications. Dr. Peck
3:30- 3:45	Recess
3:45- 4:15	Pregnancy. Dr. Root
4:15- 5:00	Summary and Question and Answer Period. Dr. Peck and Dr. Root
8:00	Public Meeting — Williams Park

Moderator — Mr. Ray Townsend, President, Lay Diabetes Society of St. Petersburg

Speakers — Dr. Peck, Dr. Root, Dr. Smith

Seminar on Gastroenterology
June 18-20, 1953

Jacksonville
George Washington Hotel

FACULTY

Dr. H. Marvin Pollard, Professor of Internal Medicine, University of Michigan, Ann Arbor, Mich.

SCHEDULE

THURSDAY, JUNE 18

9:00- 9:30	Registration
9:30-10:15	Introductory Remarks Regarding the Evaluation of Gastrointestinal Complaints
10:15-10:30	Recess
10:30-11:30	Lesions of the Esophagus and Gastric Cardia
11:30-12:00	Gastritis and Gastroscopy
2:00- 3:30	The Problem of Gastric Carcinoma: (a) Gastric Cytology, (b) Gastric Carcinoma and (c) Differentiation Between Benign and Malignant Ulcer
3:30- 3:45	Recess
3:45- 4:45	Peptic Ulcer Management

FRIDAY, JUNE 19

9:30-10:15	Ileitis, Ileojejunitis and Nontropical Sprue
10:15-10:45	Recess
10:45-11:30	Chronic Ulcerative Colitis
11:30-12:15	Carcinoma of the Colon
2:00- 3:00	Dysenteries
3:00- 3:15	Recess
3:15- 4:15	Hepatitis, Acute and Chronic
4:15- 5:00	Pancreatitis

SATURDAY, JUNE 20

9:30-12:00	Clinic and Question Period

F. M. A. Exhibit at Orlando Fair

Four physicians and a staff of 88 persons combined their talents and professional skills to make the third showing of the Florida Medical Association's fair exhibit an outstanding event. Under sponsorship of the Orange County Medical Society, the exhibit was displayed at the Central Florida Exposition, Orlando, Feb. 23-28, 1953.

The showing was directed by a Committee on Arrangements within the Society. Making up the committee were Dr. Charles J. Collins, chairman; Dr. George R. Kerr; Dr. W. Dean Steward, and Dr. William S. Mitchell. Dr. Kerr supervised blood typing; Dr. Steward, blood pressure, and Dr. Mitchell assisted with the schedule for the Woman's Auxiliary. Cooperating institutions were Orange Memorial Hospital, Central Florida Blood Bank, Florida Sanitarium and Hospital and various private laboratories.

Blood grouping and typing and blood pressure determinations were offered five hours each day. All institutions contributed the services of technicians and student nurses checking blood pressures were from the Schools of Nursing of both hospitals. Assisting the technicians were members of the Woman's Auxiliary to the Orange County Medical Society.

A total of 3,522 persons were recorded as having passed through both lines. Of these 840 had their blood typed and 2,682 had their blood pressure taken. Some 8,555 pieces of literature were handed out.

Student nurses, technicians and Auxiliary members were on duty for two shifts — 2-5 p.m. and 7-9 p.m. The working time was broken at the dinner hour on recommendation of Exposition officials. The exhibit was shown from 9 a.m to 10 p.m. and literature was arranged on tables to

Visitors to the F.M.A. Fair Exhibit at the Central Florida Exposition, Orlando, Feb. 23-28, 1953, line up to have their blood typed. Student nurses check blood pressures at the opposite end of the exhibit.

make picking it up easy. Each piece had been stamped "Courtesy of the Florida Medical Association." Very little of this literature could be found in the aisles at the closing hour in contrast with the piles of material picked up from other exhibitors and cast aside.

This was the first time the exhibit had been shown in a wall booth. It was designed for center space, to be seen from all sides. The effect of its dominating colors — white, gold and green — directly against the white wall was pleasing. The 600 square feet of floor space required for its showing was also painted green, pointing up the effect.

Newspaper publicity regarding the display of the exhibit began when Mayor J. Rolfe Davis, of Orlando, was photographed having his blood typed. On the following day student nurses were pictured taking blood pressures and from this beginning nearly all stories in the papers about the Exposition mentioned the exhibit.

The exhibit was first shown in February, 1952, during the Florida State Fair, at Tampa. The following October it was set up at Tallahassee for the North Florida Fair. Including the Central Florida Exposition, 16,189 persons have passed through the blood typing and blood pressure lines.

A.M.A. Annual Meeting New York, June 1-5, 1953

The American Medical Association goes to New York City next month for its one hundred second annual session. This meeting, to be held during the week of June 1 to 5, is the first to take place in the great metropolis since 1940 and bids fair to be the most outstanding in that organization's long history. It is anticipated that the total attendance may well exceed the record set at the centennial meeting in Atlantic City in 1947.

The Waldorf Astoria will be the headquarters hotel, and the general scientific sessions will be held in the grand ballroom of the Hotel Commodore. The Grand Central Palace, only one block from the Waldorf Astoria, will house the scientific and technical exhibits.

The broad variety and scope of the subjects scheduled for presentation and discussion in the various sessions and exhibits promise a program of wide appeal suited to the needs and tastes of everyone. The scientific exhibits are expected to be of unusually high caliber, as are the technical and commercial exhibits also. The extraordinary number of applicants has necessitated rigid screening with assurance of exceptional quality which should evoke keen interest on the part of general practitioners and specialists alike.

The color telecasts piped through closed circuits to the Hendrik Hudson Room of the Roosevelt Hotel will be of special interest to all in attendance at the convention. In the over-all educational program which is the primary objective of every A.M.A. convention, this feature has now become an accepted and popular technic.

On Tuesday evening of the convention week the inaugural ceremonies of President-elect Edward J. McCormick and the new officers will take place in the auditorium of Hunter College. This meeting will be open to the public and will be broadcast over a national radio network.

President Louis H. Bauer, a New York State physician of nearby Hempstead, will deliver his valedictory on familiar ground which the nationwide profession delights to visit. Certainly New York City with its unparalleled social, cultural, business and amusement attractions offers innumerable opportunities for diversion and relaxation. "We want you, when you leave us," says Dr. J. Stanley Kenney, the general chairman of the local committee on arrangements, "to carry with you the pleasant and long-lasting memory of a most impressive and satisfying experience." Doctors by the thousands, including a representative number from Florida, will doubtless do just that.

Basic Policy for Gamma Globulin Distribution

The Office of Defense Mobilization has now determined basic policy for distribution to the states of gamma globulin under nonepidemic poliomyelitis conditions. It has notified all state and territorial health officers of the following decision:

"(1) Around May 1 each state, on request of its state heath officer, will receive an initial allocation based on 40 cc times the median number of reported cases in that state for the 5-year period ending in 1951.

"(2) Total basic allotment for the year will be determined for each state on the basis of 40 cc times the number of reported clinically diagnosed cases during the current year.

"(3) State health officers will make available to individual physicians sufficient gamma globulin

to give inoculations to patients who have had intimate contact with clinically diagnosed cases. ODM is leaving up to the individual physician the determination of what is intimate contact."

The remaining major part of gamma globulin for polio will be kept in a national pool to be sent to epidemic areas when need arises. It is expected that the final word on distribution policy under epidemic situations will be announced soon. This decision involves determining what constitutes an epidemic and what portion of the population will get inoculations in epidemic areas.

The total national supply of gamma globulin for polio this year is estimated by the Office of Defense Mobilization as between 6 and 7 million cc. Another 2 million cc. is being earmarked for measles and infectious hepatitis. This agency said that the American Red Cross is packaging the serum for polio in 10 cc. vials which will be marked "Poliomyelitis Immune Globulin."

BIRTHS AND DEATHS

Births

Dr. and Mrs. Richard A. Bagby of Tampa announce the birth of a daughter, Cynthia, on March 3, 1953.

Dr. and Mrs. Bernard L. N. Morgan of Jacksonville announce the birth of a daughter, Lesley Cynthia, on March 9, 1953.

Deaths — Members

Perez, Joseph, DeLand	March 6, 1953
McKinnon, Daniel A., Marianna	March 17, 1953
Cordes, Henry B., Frostproof	March 30, 1953

Deaths — Other Doctors

Elsen, Matt, Winnebago, Ill.	Nov. 2, 1952
Crossley, Elijah R., Chicago	Jan. 23, 1953
Shanks, Edgar D., Atlanta, Ga.	Feb. 12, 1953
Ives, W. M., Lake City	March 30, 1953

NOTICE

This May Journal carries the new officers and committeemen with the exception of the president-elect, vice presidents, secretary - treasurer and editor of The Journal. The names of these officers are omitted because the May Journal went to press before the election of officers by the House of Delegates, April 29.

All new officers will be listed in your June Journal, as will be the personnel of The Journal staff for 1953.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Aliff, Robert C., Tampa
Andrews, Carl E., West Palm Beach
Archie, Edward O., (Col.), Tampa
Bennett, David D., Jr., Callahan
Carter, Gerard F., Jacksonville
Fleming, James C., Dunedin
Foster, Richard L., Ft. Lauderdale
Gayden, John M., Melbourne
Herr, Paul S., St. Petersburg
Hoyt, Thomas L., Pensacola
Kartsonis, Apostolos A., Starke
Kaufman, Harold S., Miami Beach
LaRoche, Laurent P., Cocoa
McClanathan, Donald E., St. Petersburg
Morgan, Bernard L. N., Jacksonville
Muir, Ian W., Sanford
Philips, Benjamin J., Jr., Jacksonville
Porter, Fred F., Titusville
Reddick, Hilliard R., Quincy
Reece, John W., Milton
Ross, Maurice E., Dunedin
Rosser, Robert G., Jr., Jacksonville
Schulz, Richard H., Marianna
Schulz, Sarah M., Marianna
Smith, Freddie A., (Col.), Sanford
Taylor, Willard M., Fort Lauderdale
Vaughm, Phyllis P., South Miami
Vincenti, Fred A., Howey-in-the-Hills
Williams, Reden R., (Col.), Tampa
Wimbish, Ralph M., (Col.), St. Petersburg
Winslow, Oliver P., Jr., Miami
Wolf, Earl G., Pensacola
Worsham, Richard A., Jacksonville

Medical Officers Returned

Dr. Talmadge S. Thompson, who entered military service on Feb. 12, 1951, was released from active duty on Feb. 12, 1953 with the rank of Captain, USAF, MC. His address is 504 Venezia Parkway, Venice.

STATE NEWS ITEMS

The following members of the Florida Medical Association were registered at the meeting of the Southeastern Surgical Congress held in Louisville, Ky., March 9-12: Drs. Hugh Crawford, Achille A. Monaco and Ellsworth F. Waite, Daytona Beach; John T. Stage, Jacksonville; Walter C. Jones and Joseph S. Stewart, Miami; Eugene L. Jewett and Ernest J. Stevens, Orlando; Frank E. Tugwell, Pensacola; William G. Meriwether, Plant City; Julius C. Davis, Quincy; Francis T. Holland and Charles F. James, Jr., Tallahassee; Wade C. Myers, Jr., Julian C. Pate, Jr., and Hawley H. Seiler, Tampa, and Raymond S. Roy, West Palm Beach.

Dr. Julius C. Davis of Quincy is councilor for Florida for the Southeastern Surgical Congress.

At a recent meeting of the newly installed Miami USAR Chapter of the Reserve Officers Association, Lt. Col. Paul S. Roland, MC, USAR, Miami Beach, was elected President of the Chapter.

Dr. Authur J. Butt of Pensacola recently presented a series of addresses to the Detroit Urological Society on "Newer Concepts Concerning the Etiology, Treatment and Prevention of Renal Lithiasis," and to the Toledo Academy of Medicine on the "Effect of Hyaluronidase, ACTH, Cortisone and Stress on the Protective Urinary Colloids and Their Relationship to Renal Calculous Disease." Dr. Butt was elected to honorary membership in the Detroit Society.

The Mount Sinai Hospital of Greater Miami announces its Third Annual Seminar on Recent Advances in Diagnosis and Therapy will be held May 21-23, 1953, at the Delano Hotel, Miami Beach.

Eight outstanding lecturers from leading medical schools throughout the nation will conduct the seminar. Subjects to be presented include chemotherapy, psychomatism, heart disease, the thyroid, metabolism, hematology, allergy and endocrinology. Panel discussion will follow each session.

The registration is limited to 300, and the registration fee is $20 (cocktail party, banquet, $7.50 optional).

For additional information write to Chairman, Seminar Committee, Mount Sinai Hospital of Greater Miami, Miami Beach.

Dr. Franz H. Stewart of Miami announces that the Southern Society of Cancer Cytology has been formed and two meetings have been held by those physicians who have expressed an interest in cancer cytology study. The group includes pathologists, gynecologists, those interested in special cytology work and other physicians interested in the field. There will be another meeting in conjunction with the Southern Medical Association meeting in Atlanta in November of this year. Membership in this Society is open to physicians, scientists, research workers and associate membership is available for technicians in the field of cancer cytology. The president of the association is Dr. F. Bayard Carter, Professor of Obstetrics and Gynecology, Duke University.

Dr. Cornelia M. Carithers of Jacksonville was guest speaker at a recent meeting of the Jacksonville Alliance of Delta Delta Delta.

Dr. Joshua M. Price of Live Oak will be honored on May 21 for his nearly 50 years of service to Suwannee County. The celebration will begin with a parade to be followed by a program and picnic lunch on the Live Oak football field. A memorial will be erected on the hospital grounds dedicated to Dr. Price and a framed picture of the doctor will be made and presented to him.

Dr. Charles McD. Harris of West Palm Beach spoke recently at a meeting of the district representatives of the Florida Division of the American Cancer Society in that city.

Dr. Wesley W. Wilson of Tampa spoke on occupational skin diseases, from both irritant and allergic causes, recently at a meeting of the Rotary Club of Bartow.

Drs. Irvin S. Leinbach of St. Petersburg and H. Phillip Hampton of Tampa took part in a talk on "Interrogation of Medical Witnesses" at the Legal Institute in St. Petersburg recently. Special guests of the Institute were members of the Pinellas County Medical Society.

Drs. Herbert B. Lott and Lewis T. Corum of Tampa will serve as co-chairmen of the Community Coordinating Council Adoptions Committee. The Committee coordinates agencies concerned with adoptions, welfare, medical and legal aspects and prospective foster parents.

Dr. Vincent P. Corso of Miami spoke on an American Cancer Society program sponsored by Alpha Epsilon Delta, honorary pre-medical fraternity, at the University of Miami in March. The program included two films, "Man Alive," and "A Question in Time."

Dr. Clarence M. Sharp of Jacksonville, director of the tuberculosis division, Florida State Board of Health, was principal speaker at a recent meeting of the Hillsborough County Tuberculosis and Health Association in Tampa.

Dr. John A. Mease, Jr., of Dunedin spoke at a recent meeting of the Dunedin Rotary Club.

Dr. H. Phillip Hampton of Tampa spoke on "Diet for Diabetics" at a recent meeting of the Tampa Dietetic Association.

Dr. Edward Canipelli of Jacksonville spoke on cancer at a recent meeting of the Jacksonville Civitan Club.

Dr. Joseph B. Ganey of Bradenton gave a talk illustrated with slides before members of District 19, Florida State Nurses Association, recently.

Dr. A. Judson Graves of Jacksonville spoke to the Meninak Club of that city recently on the importance of supporting the annual Cancer Crusade.

Dr. Frank G. Slaughter of Jacksonville spoke at the annual banquet of the Florida Historical Society at The Commons, Florida Southern College, during the Society's 97th Annual Convention. Dr. Slaughter's subject was "History and the Novelist."

Dr. George F. Schmitt, Jr., of Miami spoke at March meetings of the Hialeah-Miami Springs Kiwanis Club and the Business and Professional Woman's Club of Key West.

Ceremonies inaugurating A.M.A. President-elect Edward J. McCormick will be broadcast coast to coast Wednesday evening, June 3, from New York City. Although the inauguration will be held Tuesday, June 2, a later re-broadcast is necessary due to extensive radio coverage of the coronation of Queen Elizabeth II of England on this same day.

In television areas, the half-hour "March of Medicine" program, originating at the Scientific Exhibit in New York's Grand Central Palace, will be presented either Thursday or Friday evening, June 4 or 5. This television coverage will be sponsored by Smith, Kline and French, Philadelphia pharmaceutical firm.

Consult your local newspaper or radio stations for the exact time of these A.M.A. radio and television presentations.

Dr. John R. Browning of Jacksonville attended a postgraduate seminar in Urology held in Cleveland in December.

Drs. Ben J. Sheppard of Coral Gables, Edward H. Williams and Edwin G. Neal of Miami, and Melvyn J. Gardner and Lewis Capland of Miami Beach have recently appeared on the Dade County Medical Association television program, "Modern World."

Dr. W. W. Rogers of Jacksonville spoke on "Tuberculosis" at the February meeting of the Robert E. Lee High School P.-T.A.

Drs. Wilbur C. Sumner and Ashbel C. Williams of Jacksonville attended the meetings of the James Ewing Society held in New York City in March. Dr. Sumner gave a paper on "Spontaneous Regression of a Malignant Melanoma with Metastases."

Dr. Wiley M. Sams of Miami has been chosen chairman of the newly-formed Metropolitan Miami Dermatological Society. Dr. Rothwell Lefholz of Miami is vice chairman, and Dr. Bruce M. Esplin of Miami is secretary-treasurer.

Dr. Frank B. Hodnette of Pensacola entered the United States Air Force on Feb. 28, 1953.

The scientific article, "Management of an Outbreak of Anthrax," by Drs. Scottie J. Wilson, Paul W. Hughes, and Alfred E. Cronkite, all of Fort Lauderdale, which appeared in the December issue of The Journal, has been abstracted by the Medical Abstract Service. The Service is published by the Physicians' Record Co. of Chicago. This paper was read at the 1952 meeting of the Association in Hollywood last April.

Dr. Hugh A. Carithers of Jacksonville attended the meetings of the Florida Children's Commission in March in St. Augustine. He was also in Washington recently for a meeting of the Foetus and Newborn Committee of the American Academy of Pediatrics.

Dr. Frank G. Slaughter of Jacksonville spoke on how to turn "Facts into Fiction" at a joint meeting of the Lake Shore Dad's Club and the P.-T.A. in March.

Dr. Reuben B. Chrisman, Jr., of Miami presented a paper, "Cytology: An Aid in Early Diagnosis of Cancer of the Cervix," at the Twenty-First Assembly of the Southeastern Surgical Congress in Louisville, Ky., in March.

Dr. W. Tracy Haverfield of Miami spoke before the staff of the Gorgas Hospital in Panama recently on "Head Injuries — Their Diagnosis and Management."

Dr. Jack H. Bowen of Jacksonville attended the Louisiana State Dermatology meeting in New Orleans recently.

Dr. John T. Stage of Jacksonville gave a paper on "Postoperative Shock" before the Southeastern Surgical Congress Graduate Assembly in Louisville, Ky., in March.

Dr. Anne L. Hendricks of Fort Lauderdale spoke on Alcoholism at a recent meeting of the Zonta Club of that city.

Dr. Walter W. Newbern of West Palm Beach spoke on "Chest Surgery and Post Operative Care of the Patient," at a special meeting of District 9, Florida State Nurses Association, in that city recently.

Dr. Milton C. Maloney of Jacksonville spoke on "Cancer" before the March meeting of the Garden City P.-T.A.

Dr. Lawrence E. Geeslin of Jacksonville was elected to serve as a vice-president of the Community Chest Board of that city for the ensuing year. Dr. G. Dekle Taylor of Jacksonville was re-elected as a member of the Board.

Winners in the 1953 essay contest on the subject "Why the Private Practice of Medicine Furnishes This Country with the Finest Medical Care" have been announced by Dr. Eugene B. Maxwell, Tampa, chairman of the Association's Committee on Public Relations. Walter Afield, St. Petersburg, has been awarded first prize; Joyce Bartz, Fort Lauderdale, second prize, and Laura Osborn, Bradenton, third prize.

Dr. Jere W. Annis of Lakeland was chairman of the judging committee. Assisting him were Rogers Whitener and John D. Byrd, members of the faculty of Florida Southern College.

Dr. Lauren M. Sompayrac of Jacksonville presided at a luncheon meeting of the Phi Delta Theta Alumni Association of that city in March.

Dr. John F. Lovejoy of Jacksonville took part in an Institute on Health and Recreation for the Handicapped held in Jacksonville in February. It was sponsored by the Exceptional Child Department of the public school system.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

FOR RENT: Lincoln Road office, Miami Beach. Waiting room furnished. Reasonable. Write 69-79, P. O. Box 1018, Jacksonville, Fla.

WANTED: Internist or General Practitioner for furnished office in northeast section of Miami. Write 69-80, P. O. Box 1018, Jacksonville, Fla.

PEDIATRICIAN: 39, Board eligible, desires location, association or group. Miami. Married, family, willing to invest. Best references. Write 69-87, P. O. Box 1018, Jacksonville, Fla.

FOR SALE: Physician and Surgeon's office and residence, combined. Modern. For price of real estate alone. Retiring. Will introduce. Terms if desired. St. Petersburg. Write 69-90, P. O. Box 1018, Jacksonville, Fla.

WANTED GENERAL SURGERY PRECEPTORSHIP: Completing residency training for Boards. Surgical experience in service and private practice. Age 42, family, Emory graduate, Florida license. Available July. Write 69-91, P. O. Box 1018, Jacksonville, Fla.

Childhood constipation deserves treatment which gently restores normal peristaltic movements; drastic elimination cannot permanently correct the condition and may be harmful to the child.

ROLE OF METAMUCIL® IN ESTABLISHING PROPER BOWEL HABITS IN CHILDREN

Metamucil's bland, demulcent bulk is a physiologic way to manage bowel dysfunction in youngsters.

Metamucil does more than merely clear the constipated bowel. When taken with adequate amounts of water, Metamucil's hydrophilic colloid has a proved corrective effect on the child's misfunctioning intestines. Use of Metamucil early in life assures a natural method of elimination and helps guard against formation of the "laxative habit" in later years.

Mixed with fruit juice, milk or the child's favorite beverage, Metamucil provides a gentle, corrective stimulation to peristalsis. There is never a "rush"—never a weakening diarrhea with Metamucil.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

SEARLE Research in the Service of Medicine

COMPONENT SOCIETY NOTES

Bay

At the regular monthly meeting of the Bay County Medical Society on March 3, Dr. Edward T. Buford, Jr., had as a guest speaker Dr. E. T. Odum, who spoke on some of the problems of Acute Rheumatic Fever. Dr. Odum is considered one of the outstanding Negro physicians. He is Chief of the Medical Department, VA Hospital, Tuskeegee, Ala.; former Professor of Medicine at Meharry Medical College, Nashville, Tenn.; and a Diplomate of the American Board of Internal Medicine.

Broward

Dr. Brendan D. Leahy, instructor of ophthalmology at Harvard University, assistant surgeon of the Massachusetts General Hospital in Boston and Chief Ophthalmologist in the Lowell, Mass., Hospital, spoke at the February meeting of the Broward County Medical Association. He spoke on the use of corneal grafts to restore sight in certain types of blindness, and also explained various surgical aspects of plastic surgical repair following removal of malignant growths in scar tissue in case of burns and accidental loss of tissue about the face and eyelids.

Dade

Dr. Franklin M. Hanger, professor of medicine at the College of Physicians and Surgeons, Columbia University, spoke to members of the Dade County Medical Association on March 16 on "Hepatic Aspects of Congestive Heart Failure." This was one of a series of scientific meetings sponsored by the Heart Association of Greater Miami.

At the April Meeting of the Dade County Medical Association, Drs. George D. Lilly, Donald W. Smith, Joseph T. Jana, Jr., and Charles F. Biggane, Jr., spoke on "Evaluation of Lumbar Sympathectomy in Arteriosclerotic Circulatory Insufficiency of Lower Extremities."

The Dade County Medical Association's first medical forum for the public opened a four to six weeks series of presentations on April 14 at the Dade County Auditorium. The forum is being sponsored jointly by the Miami Herald, Dade County Medical Association and the Dade County Health Department. The subjects for discussion will be chosen by coupons made available to the public through the Miami Herald. Drs. Christian Keedy, Joseph T. Jana, Jr., Richard C. Clay and Howard A. Engle comprise the forum committee.

Just Off the Press!

HEART and CIRCULATION
DIAGNOSIS and TREATMENT

by MEYER SCLAR, M.D., F.A.C.C.

"THIS BOOK was written specially for the General Practitioner and the Medical Student. The basic concepts of diagnosis and treatment, in the field of cardiology, are presented in such a manner that both the physician and student will find their approach to cardiac patients greatly simplified. In a manual of this sort it is impossible to cover the entire field of cardiovascular disease in detail, but an attempt has been made to describe all the commonly found cardiac conditions and their management. The rare and controversial concepts are mentioned more briefly." — *From the author's preface.*

Crown octavo. Finely printed and bound.
352 pages. Fully illustrated.

Price: $7.50

Send your order to:

FROBEN PRESS, INC.
Medical Publishers
1776 BROADWAY, NEW YORK 19, N. Y.

DeSoto-Hardee-Highlands-Glades

The DeSoto-Hardee-Highlands-Glades County Medical Society has paid 100 per cent of its state for 1953.

Duval

At the regular April meeting of the Duval County Medical Society, Dr. Robert B. McIver, Association president, spoke on "The Florida Medical Association and You," and Dr. Lorenzo L. Parks of Jacksonville spoke on "Are Speeding, Open Sirens and Red-Light-Breaking by Ambulances Necessary?" A movie entitled, "Migraine: Diagnosis and Treatment," was also shown.

Escambia

The Escambia County Medical Society has paid 100 per cent of its state dues for 1953.

Hillsborough

Dr. Clark David Brooks, attending surgeon at Harper Hospital and Children's Hospital in Detroit, addressed the Hillsborough County Medical Association at its March meeting on "Surgery of the Gallbladder." Dr. Brooks also is consulting surgeon of the City of Detroit, of Receiving Hospital and Highland Park General Hospital, and a professor of surgery at Wayne University Medical School.

At the April meeting of the Association, Dr. H. Dabney Kerr of Iowa City, Iowa, spoke on "Present Concepts of the Treatment of Carcinoma of the Cervix," and Dr. Ralph S. Bromer of Bryn Mawr, Pa., spoke on "The Roentgen Examination of the Gastro Intestinal Tract in Infants and Children."

Lake

The Lake County Medical Society's exhibit at the Lake County Fair and Sportsmen's Exposition held in Eustis, March 16-21, graphically portrayed "You and Your Body." Dr. J. Basil Hall, Tavares, secretary of the Society, was in charge of arrangements.

Marion

Guest speaker at the monthly meeting of the Marion County Medical Society held March 24 was Dr. Andrew A. Eggstom of Mt. Vernon, N. Y. Dr. Eggstom is president of the Medical Society of New York, and a delegate to the A.M.A. House of Delegates. He is a pathologist at the Manhattan Eye and Ear Infirmary in New York City.

Advertisement

From where I sit
by Joe Marsh

Chip Pulls a "Pip"

Chip Hanson is a clever commercial artist. Besides doing cartoons on our paper, he picks up "free lance" drawing jobs.

Right now he's whipping up some posters for the Safety Campaign. They all have headlines like "PLAY IT SAFE!" . . . or, "A LIVE WIRE CAN START A FIRE!"

Chip looked a bit sheepish yesterday. Didn't want to tell me why. Finally he blurted out, "I feel like a dope. Here I am on this safety program and the fire inspectors tell me *my own studio's a fire trap.* I've been storing paint there for years . . ."

From where I sit, what happened to Chip could happen to anyone. He was just too busy informing everyone else about safety—not realizing his safety was threatened. Like those who fret about their neighbors—how they should practice their profession, whether they should have coffee or a glass of beer with lunch—Chip simply forgot to "draw" some obvious conclusions about himself!

Joe Marsh

Copyright, 1953, United States Brewers Foundation

THE
BROWN SCHOOLS
For Exceptional Children

Year-round school, including Summer Camp, for children, tiny tots through teens, with educational and emotional problems. Six separate residence centers, both suburban and ranch, for homogeneous grouping; complete recreational and academic programs. Under the daily supervision of a Certified Psychiatrist. Full time Psychologist and Registered Nurses. Write today for View Book; full details.

BERT P. BROWN
President

PAUL L. WHITE, M.D., F.A.P.A.
Medical Director

P. O. Box 4008-J
AUSTIN, TEXAS

THE
MEDICAL PROTECTIVE
COMPANY
FORT WAYNE, INDIANA

PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899

specialized service
assures *"know-how"*

ST. PETERSBURG Office:
Calvin Bimer, Rep.,
240 Mateo Way, Snell Isle,
Telephone 73-289

Pasco-Hernando-Citrus

The Pasco-Hernando-Citrus County Medical Society has paid 100 per cent of its state dues for 1953.

Pinellas

Members of the Pinellas County Medical Society were special guests at the Legal Institute sponsored recently by the Legal Institute of the Florida Bar Association in St. Petersburg.

Guest speaker at the regular monthly meeting of the Society on April 6 was Dr. James D. Moody of Orlando who spoke on "Surgical Approach to Heart Disease."

Polk

Dr. McGeehee Harvey, professor of medicine at Johns Hopkins University School of Medicine, was guest speaker at the March meeting of the Polk County Medical Society. His subject was "Newer Treatments." Lake Wales doctors were hosts for the meeting which was held at the Bonaire Lodge on March 11.

The fourth in a series of Medical Forums sponsored by the Polk County Medical Society, the Lakeland Ledger and the Kiwanis Club of Lakeland was held on April 13. The Forums which began March 23 with a discussion of Blood Pressure are being held in the Lakeland Auditorium. Each Forum has been limited to one hour with starting time at 8 p.m. They are opened with a 20 minute discussion of the chosen topic by a physician. The remaining time is allotted to a question and answer session. Polk county doctors sit on the panel.

The Ledger Sunday edition carries a coupon for use in submitting questions. All must be in by Saturday preceding the scheduled topic's discussion on Monday night. Announcement that the Forums would be held was made jointly by Dr. Jere W. Annis, president of the Society; Harris Sims, editor of the Lakeland Ledger, and John Wright, chairman of the Kiwanis Club's public affairs committee.

St. Johns

One hundred per cent of state dues for 1953 have been paid by the St. Johns County Medical Society.

Suwannee

The Suwannee County Medical Society has paid 100 per cent of its state dues for 1953.

Volusia

Dr. John L. Fromer, chief of allergy in dermatology of the Lahey Clinic, Boston, spoke before the Volusia County Medical Society on March 10. His subject was "Eczemas."

OBITUARIES

Milton Boyd Kay

Dr. Milton Boyd Kay of Miami Beach died at his home on Oct. 13, 1952. He was 71 years of age.

Born in Washington, Pa., on March 17, 1881, Dr. Boyd attended Washington and Jefferson College and in 1905 received the degree of Doctor of Medicine from the University of Pennsylvania School of Medicine. Upon completion of postgraduate studies at Johns Hopkins and Columbia universities, he located in Pittsburgh for a short time, where he was an associate professor at the University of Pittsburgh. He then accepted an associate professorship at Wayne University in Detroit.

Dr. Kay served in World War I as commanding officer of Base Hospital Unit 101 in France. He was a member of the American Legion and Veterans of Foreign Wars.

In 1934, because of ill health, Dr. Kay came to Florida, locating in Miami. He was active in the practice of pediatrics and later internal medicine in that city until the time of his final illness.

Dr. Kay was a member of the Dade County Medical Association and for 19 years held membership in the Florida Medical Association, with honorary status the last four years. He was also a member of the American Medical Association.

Surviving are the widow, Mrs. Cassie Kay, and three brothers, Ivan Kay of Miami, Vernon Kay of Chicago, and Carl Kay of San Diego, Calif.

(Cont'd on page 855)

Cook County Graduate School of Medicine

POSTGRADUATE COURSES — 1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting May 11, June 1, June 15. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting June 1. Surgical Anatomy & Clinical Surgery, Two Weeks, starting June 15, August 17. Gallbladder Surgery, Ten Hours, starting June 29. Surgery of Colon & Rectum, One Week, starting May 11. General Surgery, Two Weeks, starting October 12. Thoracic Surgery, One Week, starting June 8. Breast & Thyroid Surgery, One Week, starting June 22. Esophageal Surgery, One Week, starting June 22. Fractures & Traumatic Surgery, Two Weeks, starting June 15.

GYNECOLOGY—Intensive Course, Two Weeks, starting June 15. Vaginal Approach to Pelvic Surgery, One Week, starting June 8.

OBSTETRICS—Intensive Course, Two Weeks, starting June 8.

PEDIATRICS—Congenital Heart Disease, Two Weeks, starting May 18. Cerebral Palsy, Two Weeks, starting June 15.

MEDICINE—Gastroenterology, Two Weeks, starting May 18. Electrocardiography & Heart Disease, Two Weeks, starting July 13. Allergy, One Month and Six Months, by appointment.

CYSTOSCOPY—Ten-Day Practical Course starting every two weeks.

DERMATOLOGY—Intensive Course, Two Weeks, starting May 11.

Teaching Faculty:

Attending Staff of Cook County Hospital

Address:

Registrar, 707 South Wood Street,

Chicago 12, Illinois

W. Guy Black

HOME FOR FUNERALS
170 EAST CHURCH
TELEPHONE 2-3146

Complete Facilities
Complete Funeral Service
Call Orlando 2-3146
For Oxygen-Equipped
AMBULANCE
SERVICE
W. Guy Black
Licensed Funeral Director

"A Spacious Grounds of Miami Medical Center
Cutler Rd in Background"

MIAMI MEDICAL CENTER

P. L. DODGE, M.D.
Medical Director and President

1861 N. W. South River Drive
Phones 2-0243 — 9-1448

A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures — Psychotherapy, Insulin, Electroshock, Hydrotherapy, Diathermy and Physiotherapy when indicated. Adequate facilities for recreation and out-door activities. Cruising and fishing trips on hospital yacht.

Information on request
Member American Hospital Association

Allen's Invalid Home

MILLEDGEVILLE, GA.

Established 1890
For the treatment of
NERVOUS AND MENTAL DISEASES

Grounds 600 Acres
Buildings Brick Fireproof
Comfortable Convenient
Site High and Healthful

E. W. ALLEN, M.D., *Department for Men*
H. D. ALLEN, M.D., *Department for Women*
Terms Reasonable

CONVENTION PRESS

218 WEST CHURCH STREET
JACKSONVILLE
FLORIDA

Commercial and
Publication
Printing

BALLAST POINT MANOR

Care of Mild Mental Cases, Senile Disorders
and Invalids
Alcoholics Treated

Aged adjudged cases will be accepted on either permanent or temporary basis.

ACCREDITED HOSPITAL FOR NEUROLOGICAL PATIENTS by
American Medical Assn.
American Hospital Assn.
Florida Hospital Assn.

5226 Nichol St.
Telephone 62-2332

DON SAVAGE
Owner and Manager

P. O. Box 10368
Tampa 9, Florida

(Continued from page 853)

William Henry Spiers

Dr. William Henry Spiers of West Palm Beach died at the Veterans Administration Hospital in Coral Gables on Dec. 8, 1952. He was 67 years of age. Interment took place in Greenwood Cemetery in Orlando.

A native Floridian, Dr. Spiers was born in Jacksonville in 1885. He was the son of pioneer residents of that city, the late William P. and Melanie Gardner Spiers. After receiving his early education in local schools, he attended East Florida Seminary, and in 1914 was awarded the degree of Doctor of Medicine by the Emory University School of Medicine in Atlanta.

During World War I, Dr. Spiers saw duty overseas as a medical officer. From 1916 to 1921 he served as resident physician and superintendent of the Florida State Mental Hospital at Chattahoochee. Thereafter, he practiced in Orlando, specializing in neuropsychiatry, and for a time served as chief of the department of neurology at the Orange Memorial Hospital in that city. After his retirement in 1949 because of ill health, he resided in West Palm Beach.

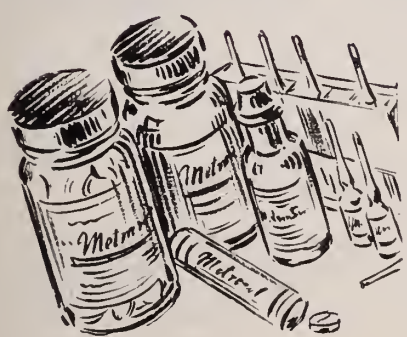
Dr. Spiers was a member and a past president of the Orange County Medical Society. For 30 years he was a member of the Florida Medical Association, holding honorary status the last two years; in 1938 he served as president of the Association. He also held membership in the American Medical Association and other medical organizations.

Surviving are one son, James K. Spiers of West Palm Beach; three sisters, Mrs. Evelyn T. Woolery, Mrs. Leonora Dieter and Mrs. Ella S. Geary, all of Jacksonville; and several nieces and nephews.

for Quick Action!

in the Respiratory and Circulatory Emergencies of Intravenous Barbiturate Anesthesia.

inject



COUNCIL ACCEPTED Metrazol

intravenously, intramuscularly, subcutaneously

In respiratory and other emergencies resulting from medullary depression during anesthesia. Ampules 1 and 3 cc., tablets, solution, powder.

Metrazol, brand of pentamethylentetrazol, Trade Mark Reg. U. S. Pat. Off., E. ilhuber, Inc., Mfr.

Bilhuber-Knoll Corp. Orange, N. J.

The Right to *Choose* . . . .

CORNERSTONE OF AMERICAN LIBERTY

Hospital Expense Plans

Medical-Surgical Expense Plans

Paycheck Protection Plans

Life Insurance Plan

AS long as Americans keep the right to choose — their church, their political party, their doctor and their hospital — freedom must prevail.

We are proud that hundreds of thousands of Americans have freely chosen the protection afforded them by PENNSYLVANIA LIFE'S liberal, low-cost health insurance plan.

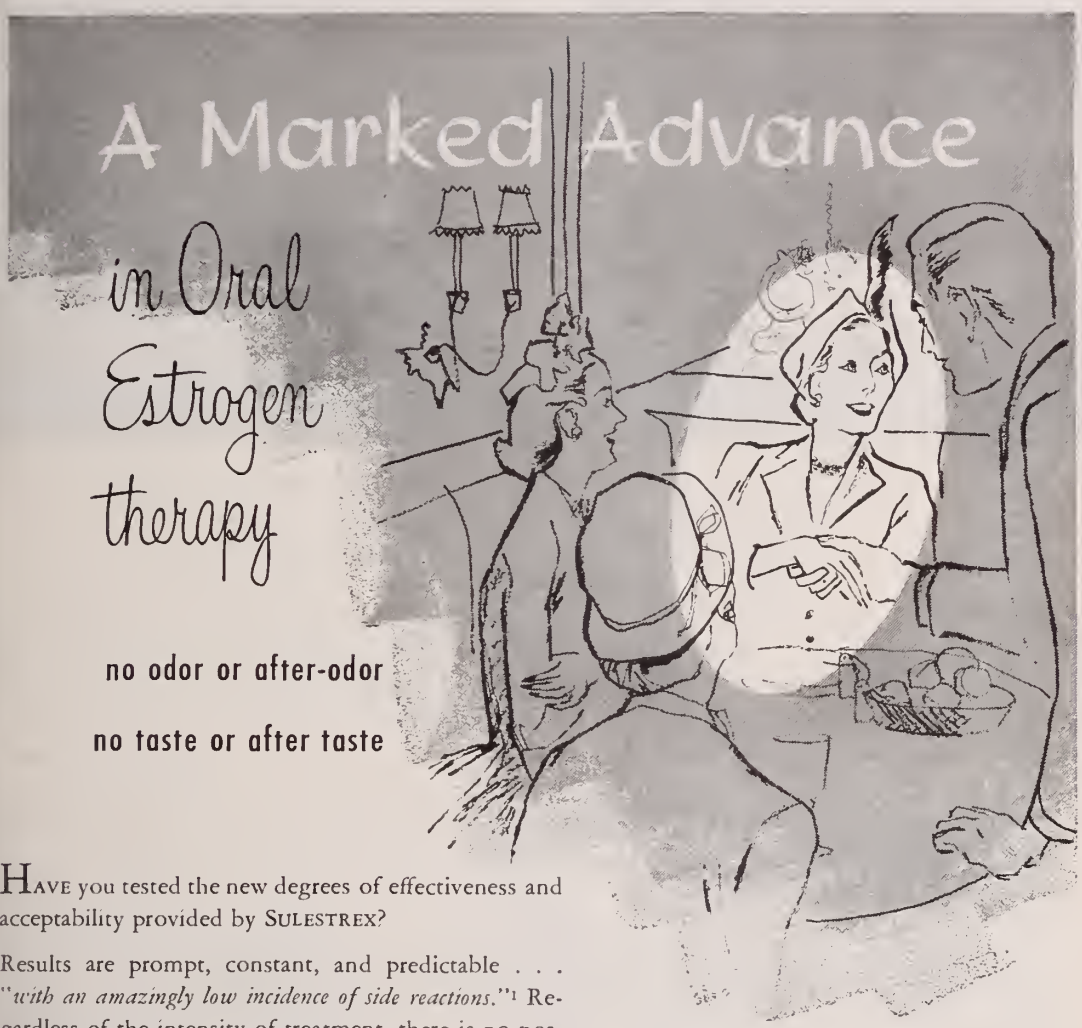
Pennsylvania Life
HEALTH & ACCIDENT **Insurance Company**

FOUNDED 1890

HOME OFFICE: PHILADELPHIA 5, PA.

19 District Offices in Florida

Miami	Executive Office 3028 Biscayne Blvd.	Fort Lauderdale	521½ South Andrew Avenue
	Downtown 1210 Pacific Building	Jacksonville	303 Clark Building
	Southwest 1260 S. W. 22nd Street	Tampa	228 Cass Street Arcade Building
	Little River 8340 N.E. Second Ave., Suite 245	Sarasota	237 Main Street, Room 15
	Coral Gables 3028 Biscayne Blvd.	Fort Pierce	Florida Bank Building, Room 34
	Miami Beach 206 Harvey Building	Daytona Beach	116½ Orange Avenue
St. Petersburg	509 White Building	Tallahassee	429 Centennial Building
Lakeland	206 Marble Arcade	Panama City	142 Harrison Avenue
West Palm Beach	305 Citizens Building	Pensacola	501 Theisen Building
Orlando	209 Slayton Building		



HAVE you tested the new degrees of effectiveness and acceptability provided by SULESTREX?

Results are prompt, constant, and predictable . . . "*with an amazingly low incidence of side reactions.*"[1] Regardless of the intensity of treatment, there is no possibility of esthetic "embarrassment."

Measure these advantages when prescribing for your next menopausal patient. SULESTREX (piperazine estrone sulfate, Abbott) provides the natural estrogen, estrone, in pure crystalline form. It is not a mixture of estrogenic agents of variable potencies. SULESTREX is stable, water-soluble, odorless and tasteless.

You may choose from three prescribing forms: Tablets,* Sub-U-Tabs,** and Elixir.* Try it soon, with this confidence: you can't prescribe a more effective oral estrogen. Abbott

Sulestrex®
Piperazine

* AMA Council Accepted
** T.M. for Sublingual Tablets, Abbott
1. Reich, W. J. et al. (1952), A Recent Advance in Estrogenic Therapy. II. Amer. J. Obst. & Gynec., 64:174, July.

1-1648

HILL CREST SANITARIUM

FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

Thoroughly modern in architecture and construction. Eight departments — affording proper classification of patients. All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

James A. Becton, M.D., Physician-in-charge — James Keene Ward, M.D., Associate Physician

P. O. Box 2896, Woodlawn Station, Birmingham, Alabama — **Phones 9-1151 and 9-1152**

TUCKER HOSPITAL, INC.

212 West Franklin Street

RICHMOND, VIRGINIA

A private hospital accepting for diagnosis and treatment organic neurological conditions, selected psychiatric and alcoholic cases, metabolic disturbances of an endocrine nature, individuals who are having difficulty with their personality adjustments, and children with behavior problems. Patients with general medical disorders admitted for treatment under our staff of visiting physicians.

Under the Professional Charge of

DR. HOWARD R. MASTERS,
DR. JAMES ASA SHIELD AND ASSOCIATES

S. A. Kyle *Funeral Director*

MEMBER National Selected Morticians BY INVITATION

17 WEST UNION STREET
JACKSONVILLE 2, FLORIDA
Phones 5-3766 5-3767

BISCAYNE HOSPITAL
6339 Biscayne Blvd.
MIAMI 38, FLORIDA

Members of the Dade County Medical Association are acquainted with the high type of service rendered.

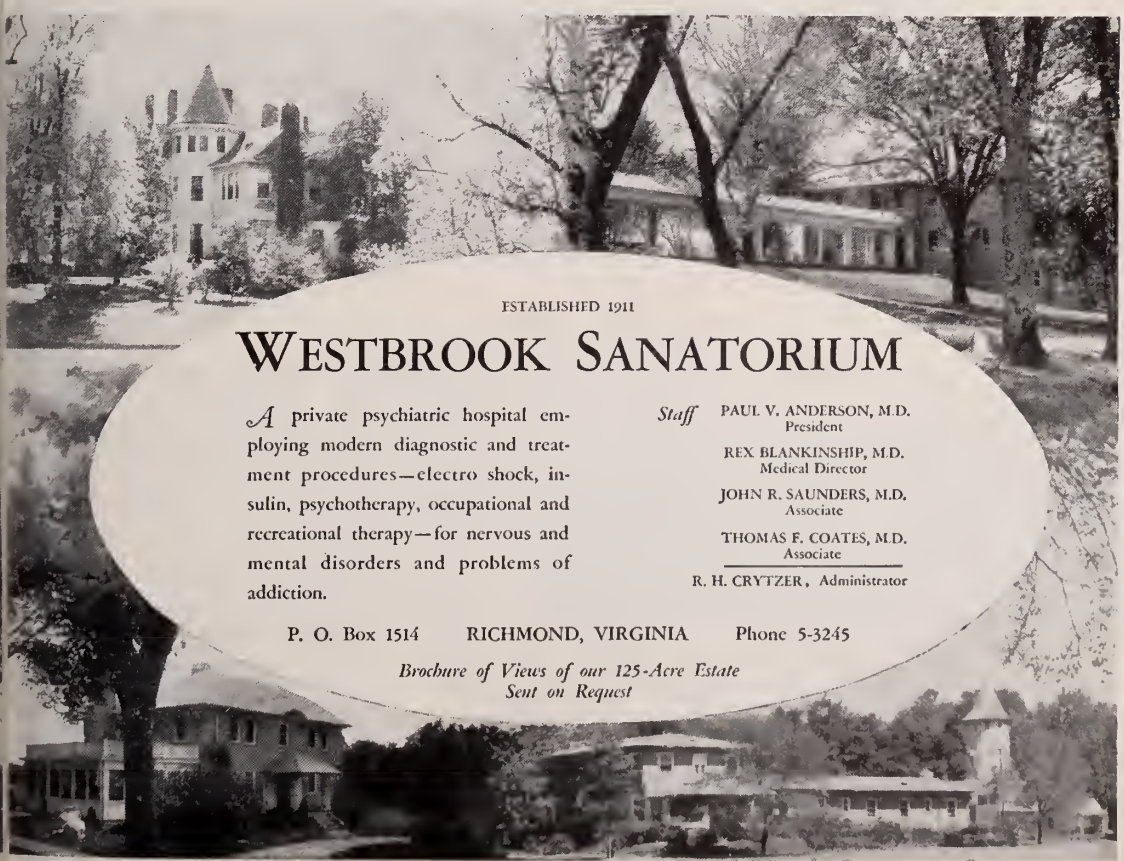
David Collins, Superintendent

Registered, American Medical Association
Phone 7-4544

MIAMI RETREAT SANATORIUM
FOUNDED 1927
For Nervous and Mental Disorders. Alcohol and Drug Addiction

STAFF OF EIGHT NEUROPSYCHIATRISTS
New X-Ray Diagnostic Treatment Facilities
Comfortable AIR-CONDITIONED rooms. suites

79TH STREET AT MIAMI AVENUE
MIAMI 38, FLORIDA
Phone 7-1824



ESTABLISHED 1911

WESTBROOK SANATORIUM

A private psychiatric hospital employing modern diagnostic and treatment procedures—electro shock, insulin, psychotherapy, occupational and recreational therapy—for nervous and mental disorders and problems of addiction.

Staff PAUL V. ANDERSON, M.D.
President
REX BLANKINSHIP, M.D.
Medical Director
JOHN R. SAUNDERS, M.D.
Associate
THOMAS F. COATES, M.D.
Associate
R. H. CRYTZER, Administrator

P. O. Box 1514 RICHMOND, VIRGINIA Phone 5-3245

Brochure of Views of our 125-Acre Estate Sent on Request

HIGHLAND HOSPITAL, INC.

FOUNDED IN 1904

Asheville, North Carolina

AFFILIATED WITH DUKE UNIVERSITY

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a sixty-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D.,
Diplomate in Psychiatry
Medical Director

ROBT. L. CRAIG, M.D.,
Diplomate in Neurology and Psychiatry
Associate Director

BRAWNER'S SANITARIUM

ESTABLISHED 1910

SMYRNA, GEORGIA

(Suburb of Atlanta)

For the Treatment of

Psychiatric Illnesses and Problems of Addiction

Psychotherapy, Convulsive Therapy, Recreational and Occupational Therapy
Modern Facilities

Custodial Care for a Limited Number of Elderly Patients at Monthly Rate

JAS. N. BRAWNER, M.D.
Medical Director

Jas. N. BRAWNER, JR., M.D.
Assistant Director and Superintendent

ALBERT F. BRAWNER, M.D.
Resident Superintendent

P. O. Box 218

Phone 5-4486

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
ota Medical Association	Frederick K. Herpel, W. Palm Bch.		
ta Medical Districts	John D. Milton, Miami	Council Chairman	
A orthwest	Francis M. Watson, Marianna	George S. Palmer, Tallahassee	Tallahassee, 1953
B ortheast	William C. Thomas, Jr., Gainesville	Thomas C. Kenaston, Cocoa	St. Augustine, 1953
C outhwest	Emmett E. Martin, Haines City	Clyde O. Anderson, St. Petersburg	Tampa, 1953
D outheast	Erasmus B. Hardee, Vero Beach	Russell B. Carson, Ft. Lauderdale	West Palm Beach, 1953
ou a Specialty Societies			
a my of General Practice	Edward F. Shaver, Tampa	Frank T. Linz, Tampa	
ie y Society	Nelson Zivitz, Miami Beach	Solomon D. Klotz, Orlando	
e iesiologists, Soc. of	John T. Stage, Jacksonville	Breckenridge W. Wing, Orlando	
a er, Am. Coll. Chest Phys.	Alexander Libow, Miami Beach	DeWitt C. Daughtry, Miami	
and Syph., Soc. of	Lewis Capland, Miami Beach	Morris Waisman, Tampa	
a Officers' Society	George W. Edwards, II, Orlando	Lorenzo L. Parks, Jacksonville	
rial & Railway Surgeons	John H. Mitchell, Jacksonville	William H. Chapman, Jacksonville	
logy & Psychiatry	W. Tracy Haverfield, Miami	Roger E. Phillips, Orlando	
d Gynec. Society	Dorothy D. Brame, Orlando	J. Champneys Taylor, Jacksonville	
al. & Otol., Soc. of	Joseph W. Taylor, Sr., Tampa	Carl S. McLemore, Orlando	
) edic Society	Arthur H. Weiland, Coral Gables	Edward W. Cullipher, Miami	
logists, Society of	Robert J. Poppiti, Miami Beach	Alfred E. Cronkite, Fort Lauderdale	
d ric Society	Charlotte C. Maguire, Orlando	Wesley S. Nock, Coral Gables	
o logic Society	Alex. E. Rosenberg, Miami Bch.	George Williams, Jr., Miami	
logical Society	Thomas H. Lipscomb, Jacksonville	A. Judson Graves, Jacksonville	
gical Society	George H. Putnam, Gainesville	David W. Goddard, Daytona Beach	
a—			
B c Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 6, '53
B d Banks, Association	Donald W. Smith, Miami	Mr. J. M. Potts, Miami	Miami, May, 1953
B · Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Miami, Dec. 3, '53
B · Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	
C cer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	
D tal Society, State	W. G. McLeod, D.D.S., Pensacola	Coleman Brown, D.D.S., Tampa	
H rt Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
H pital Association	Mr. T. F. Little, Daytona Beach	Mr. Tracy B. Hare, Miami	Miami, Nov. '53
M lical Examining Board	Ralph B. Spires, DeFuniak Springs	Homer L. Pearson, Jr., Miami	Jacksonville, June 28-30, '53
M lical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 22-27, '53
N ses Association, State	Mrs. Mary Livingston, W. P. Beach	Mrs. Idalyn Lawthon, Tampa	Tampa, Nov. '53
P maceutical Association, State	Mr. Clyde Morris, Daytona Beach	Mr. R. Q. Richards, Ft. Myers	St. Petersburg, May, '53
P lic Health Association	Mr. Angus Laird, Tallahassee	Mr. Fred B. Ragland, Jacksonville	Tampa, 1953
T erculosis & Health Assn.	Leffie M. Carlton, Jr., Tampa	Mrs. L. C. Conant, Fort Myers	Jacksonville, May 14-15, '53
W nan's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	
n an Medical Association	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	New York, June 1-5, '53
A .A. Clinical Session	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	St. Louis, Dec. '53
u rn Medical Association	Walter C. Jones, Miami	Mr. C. P. Loranz, Birmingham	Atlanta, 1953
l na Medical Association	B. W. McNease, Fayette	Douglas L. Cannon, Montgomery	
o a, Medical Assn. of	C. F. Holton, Savannah	Mr. Sid Wrightsman, Atlanta	Savannah, May 10-13, '53
E lospital Conference	Mr. Norman Losh, Orlando	Mr. D. O. McClusky, Tuscal'sa, Ala.	
u astern Allergy Assn.	Clarence Thomas, Nashville, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Nashville, May 15-16, '53
u astern, Am. Urological Assn.	William Miner, Covington, Ky.	Sidney Smith, Raleigh, N. C.	
u astern Surgical Congress	J. R. Young, Anderson, S. C.	B. T. Beasley, Atlanta	Birmingham, Mar. 8-11, '54
l oast Clinical Society	Hays Zieman, Mobile, Ala.	William Atkinson, Mobile, Ala	Mobile, Oct., '53

• In MIAMI
SANITARIUM
Medical Hospital American Plan Hotel for Patients and their families. REST, CONVALESCENCE, ACUTE and CHRONIC MEDICAL CASES. Elderly People and Invalids. *FREE Booklet!*

Acres Tropical Grounds, Delicious Meals, Res. Physician, Grad. Nurses, Dietitian.
Mild Mental Cases, Drug and Alcoholics in Separate Building

SUN-RAY PARK HEALTH RESORT

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS TOTAL	MEMBERS PAID	COUNCILOR
A	Bay	Harold E. Wager, M.D. Box 984 Panama City	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	1st Tuesday 7:30 P.M.	24	19	
A	Escambia *Santa Rosa*	Alvin L. Stebbins, M.D. 621 N. O St. Pensacola	Paul F. Baranco, M.D. 608 Blount Bldg. Pensacola	2nd Tuesday 8:00 P.M.	88	100%	
A	Franklin-Gulf	Photis J. Nichols, M.D. Apalachicola	Terry Bird, M.D. Apalachicola	Last Wednesday except Dec. & July	7	100%	A-1-54 Francis M. Watson, M.D. Marianna
A	Jackson-Calhoun	Grayson C. Snyder, M.D. Floyd Bldg. Blountstown	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	18	17	
A	Walton-Okaloosa	Edgar H. Myers, M.D. DeFuniak Springs	William D. Cawthon, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	17	100%	
A	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		5	100%	
B	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	10	
B	Leon-Gadsden-Liberty-Wakulla-Jefferson	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	T. Bert Fletcher, Jr., M.D. 516 N. Adams St. Tallahassee	Quarterly 7:30 P.M.	59	49	
B	Suwannee	Hiram B. Curry, M.D. Jasper	Edward G. Haskell, Jr., M.D. Branford	1st Saturday 9:30 A.M.	8	6	A-2-55 George S. Palmer, M.D. Tallahassee
B	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		4	3	
B	Taylor *Dixie, Lafayette*	Mark E. Adams, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	4	3	248
B	Alachua *Bradford, Gilchrist, Union*	F. Emory Bell, M.D. Box 113 Gainesville	Winston L. Summerlin, M.D. 111 S. W. 3rd St. Gainesville	2nd Tuesday 8:00 P.M.	46	42	
B	Duval *Clay*	W. W. Rogers, M.D. 962 Main St. Jacksonville	John T. Stage, M.D. 2033 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	255	160	
B	Marion *Levy*	Eugene G. Peek, Jr., M.D. Box 248 Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	28	19	B-3-54 William C. Thomas, Jr., M.D. Gainesville
B	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	12	11	
B	Putnam	Bernard E. Kane, M.D. Box 216 Crescent City	James A. Long, Jr., M.D. 1001 Main St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
B	St. Johns	John M. Canakaris, M.D. Box 295 Bunnell	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
C	Brevard	Laurent L. LaRoche, M.D. 526 Brevard Ave. Cocoa	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	2nd Tuesday	25	22	
C	Lake *Sumter*	John D. Bloom, M.D. Groveland	J. Basil Hall, M.D. Tavares	1st Wednesday 7:30 P.M.	27	24	B-4-55 Thomas C. Kenaston, M.D. Cocoa
C	Orange *Osceola*	G. Tayloe Gwathmey, M.D. 417 E. Robinson Ave. Orlando	Andrew W. Townes, Jr., M.D. 717 N. Magnolia Ave. Orlando	3rd Wednesday 8:00 P.M.	164	158	
C	Seminole	Wade H. Garner, M.D. Box 219 Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	18	100%	
C	Volusia *Flagler*	Morris B. Seltzer, M.D. 614 N. Peninsula Dr. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	82	64	681
C	Hillsborough	Arthur R. Knauf, M.D. 706 Franklin St. Tampa	Julien C. Pate, Jr., M.D. 1105 First Nat. Bk. Bldg. Tampa	1st Tuesday 8:00 P.M.	178	155	
C	Manatee	William D. Sugg, M.D. Bradenton Bank Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	19	14	
C	Pasco-Hernando-Citrus	Karl T. Humes, M.D. Box 157 Bushnell	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	18	100%	C-5-55 Clyde O. Anderson, M.D. St. Petersburg
C	Pinellas	Everett M. Harrison, M.D. 1601 N. Ft. Harrison Ave. Clearwater	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Mon. Even Mo. 1st Fri. Odd Mo. 6:00 P.M.	197	186	
C	Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	Melvin M. Simmons, M.D. 816 Florasota Gardens Sarasota	2nd Tuesday 8:30 P.M.	47	39	
D	DeSoto-Hardee-Highlands-Glades	Wesley S. Pyatt, M.D. Bowling Green	Merle C. Kayton, M.D. Wauchula	2nd Tuesday 8:00 P.M.	25	100%	
D	Lee-Charlotte-Collier-Hendry	Ernest Bostelman, M.D. 201 Pythian Bldg. Fort Myers	Harry Fagan, Jr., M.D. 310 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	29	100%	C-6-54 Emmett E. Martin, M.D. Haines City
D	Polk	Jere W. Annis, M.D. Box 1021 Lakeland	James T. Shelden, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	96	90	609
D	Indian River	John P. Gifford, M.D. 1625 Osceola Blvd. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	6	
D	Palm Beach	Graham W. King, Jr., M.D. Box 505 Delray Beach	David A. Newman, M.D. 175 Bradley Pl. Palm Beach	3rd Monday 8:00 P.M.	123	118	D-7-54 Erasmus B. Hardee, M.D. Vero Beach
D	St. Lucie-Okeechobee-Martin	John T. McDermid, M.D. 337 N. 4th St. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	16	14	
D	Broward	Claus A. Peterson, M.D. 312 Blount Bldg. Ft. Lauderdale	James M. Weaver, M.D. Box 4084 Ft. Lauderdale	4th Tuesday 8:00 P.M.	96	89	
D	Dade	Ralph W. Jack, M.D. 1700 Biscayne Blvd. Miami	Walter W. Sackett, Jr., M.D. 2500 Coral Way Miami	1st Tuesday 8:30 P.M.	627	445	D-8-55 Russell B. Carson, M.D. Fort Lauderdale
D	Monroe	Joseph L. G. Lester, Jr., M.D. 422 Fleming St. Key West	Allen S. Shepard, M.D. 638 United St. Key West	2nd Thursday 8:00 P.M.	15	9	884

*Supervise and aid until organized separately.

Total 2,4

The New Hamilton Pediatric Table No. 9903

Includes all essential features: Built-in weighing scale, height measuring scale. Hide-A-Roll, drawers, cupboards and electric outlets.

Dimensions: Height to upholstered top, 36"; overall height, 52" including scale; width between rails, 18¼"; overall width, 26"; overall length, 42". Choice of wood grain finish or colors. Specify finish desired. $404.25

$20.00 *extra for upholstered top with foam rubber padding.*

MEMBER

AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A. Quality and Service

Anderson Surgical Supply Co.

Established 1916

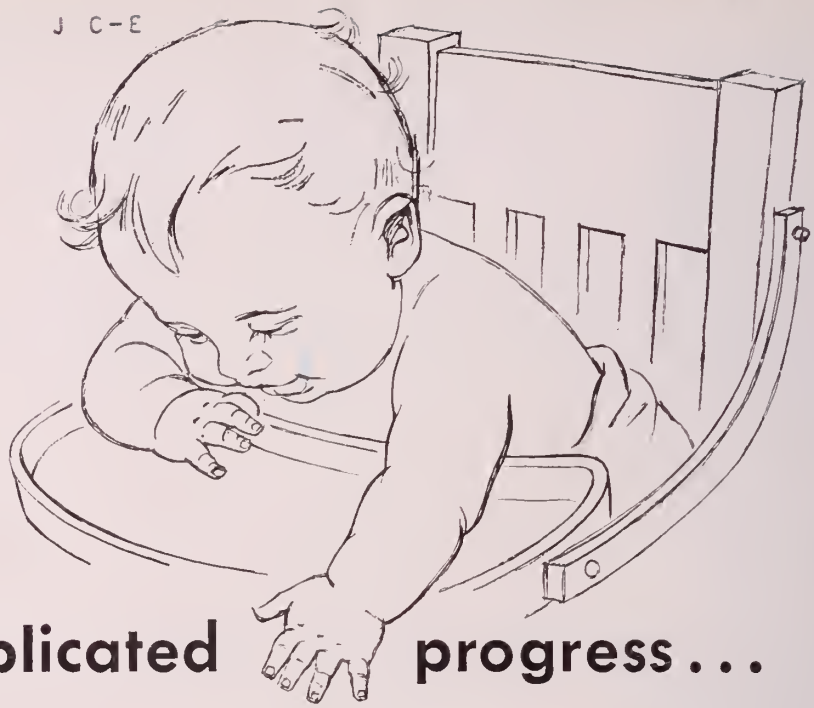
Telephone 5-2560
40-42 W. DUVAL STREET
P. O. Box 1799
JACKSONVILLE, 1, FLORIDA

Telephone M-8504
MORGAN AT PLATT
P. O. Box 1223
TAMPA 1, FLORIDA

Telephone 7-4589
21 3rd STREET N.
ST. PETERSBURG, FLORIDA

NEW YORK ACADEMY OF MEDICINE
2 E 103RD ST
NEW YORK N Y 29

J C-E



uncomplicated progress . . .

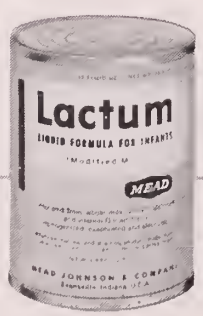
Tolerance of feedings	Good
Incidence of digestive disturbances	low
Growth response	Satisfactory
Discontinuation of night feeding	early
Health and development	excellent

The uncomplicated nutritional progress[1] of infants fed Lactum® speaks for its sound rationale. Lactum is Mead's liquid formula made from whole milk and Dextri-Maltose.®

It provides generous milk protein for sturdy growth and sound tissue structure, with sufficient calories to spare protein and meet the infant's energy needs.

Lactum is convenient and easy to prepare—simply mix equal parts of Lactum and water for a formula supplying 20 calories per fluid ounce.

1. Frost, L. H., and Jackson, R. L.: J. Pediat. 39: 585-592, 1951.



Lactum

MEAD JOHNSON & COMPANY
Evansville 21, Ind., U.S.A.

MEAD

Local Representative: Roger J. McElroy, 3181 McDonald Street, Coconut Grove 33, Florida, 4-4124.

The Journal

OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXIX JUNE, 1953 No. 12

IN THIS ISSUE

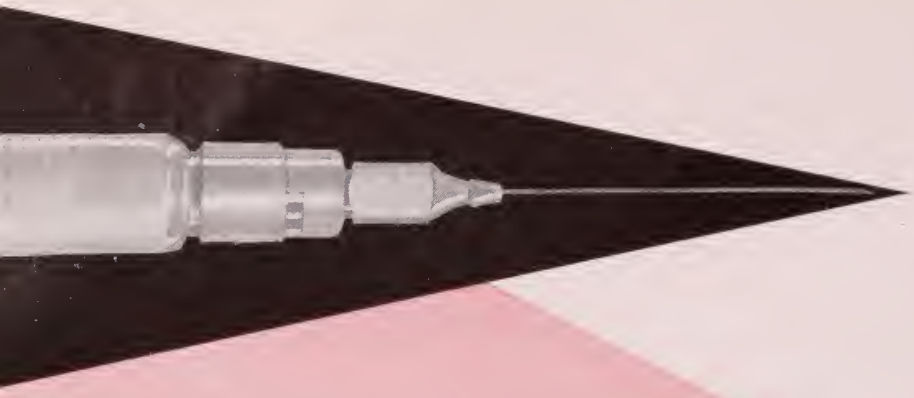
Proceedings Hollywood Convention
House of Delegates Actions
Scientific Assemblies
General Sessions

OF MEDICINE
JUN 16 1953
LIBRARY

President's Address
Robert B. McIver

Index to Volume XXXIX

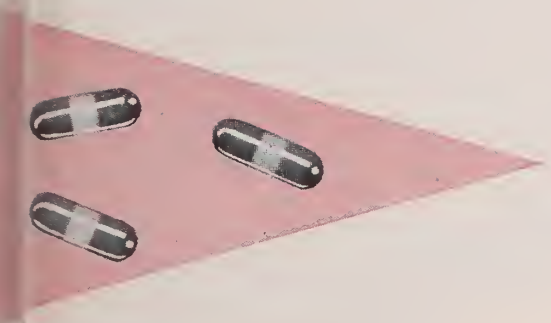
OFFICIAL PUBLICATION OF THE
FLORIDA MEDICAL ASSOCIATION



a standard measure
to avert or allay
allergic distress...

BENADRYL®

BENADRYL Hydrochloride
is available in a variety of forms—
including Kapseals,® 50 mg. each;
Capsules, 25 mg. each; Elixir,
10 mg. per teaspoonful;
and Steri-Vials,® 10 mg. per cc.
for parenteral therapy.



Whenever antihistaminic therapy is needed to prevent or relieve allergic symptoms, prescription of BENADRYL Hydrochloride (diphenhydramine hydrochloride, Parke-Davis) has become a customary procedure in the daily practice of many physicians. Because relief is rapidly obtained and gratifyingly prolonged, many thousands of patients have been spared the usual discomforts of hay fever, vasomotor rhinitis, acute and chronic urticaria, angio-neurotic edema, pruritic dermatoses, contact dermatitis, serum sickness, food allergy, and sensitization to penicillin and other drugs.

MEDICAMENTA VERA

Parke, Davis & Company

DETROIT, MICHIGAN

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

Volume XXXIX JUNE, 1953 No. 12

CONTENTS

CONVENTION EVENTS

President's Address, Robert B. McIver, M.D. 887
Proceedings of Seventy-Ninth Annual Meeting
First General Session 893
Second General Session 894
First House of Delegates 895
Second House of Delegates 897
Scientific Assemblies 915
Registration at Annual Meeting 916

ANNUAL REPORTS

Annual Joint Report of Secretary-Treasurer, Samuel M. Day, M.D., Managing Director, Stewart G. Thompson, D.P.H. 919
Report of Editor of The Journal, Dr. Shaler Richardson 925

ABSTRACTS OF MEDICAL ARTICLES

Drs. Arthur J. Butt, Barkley Beidleman, James B. Glanton, Raymond J. Fitzpatrick, Louis M. Orr, Joseph C. Hayward, F. Gordon King, and H. Clinton Davis 891

EDITORIALS AND COMMENTARIES

Stewart Gordon Thompson, In Memoriam 926
Frederick Karl Herpel, M.D., President 931
Seventy-Ninth Annual Convention 932
Convention Golf Tournament 933
Association's New Executive Head 933
History-Making Medical Event in Washington 934
The New Department of Health, Education and Welfare 934
Gamma Globulin Program for Florida 936
Play Safe with Insecticides in the Home 937
Southern Pediatric Seminar 937

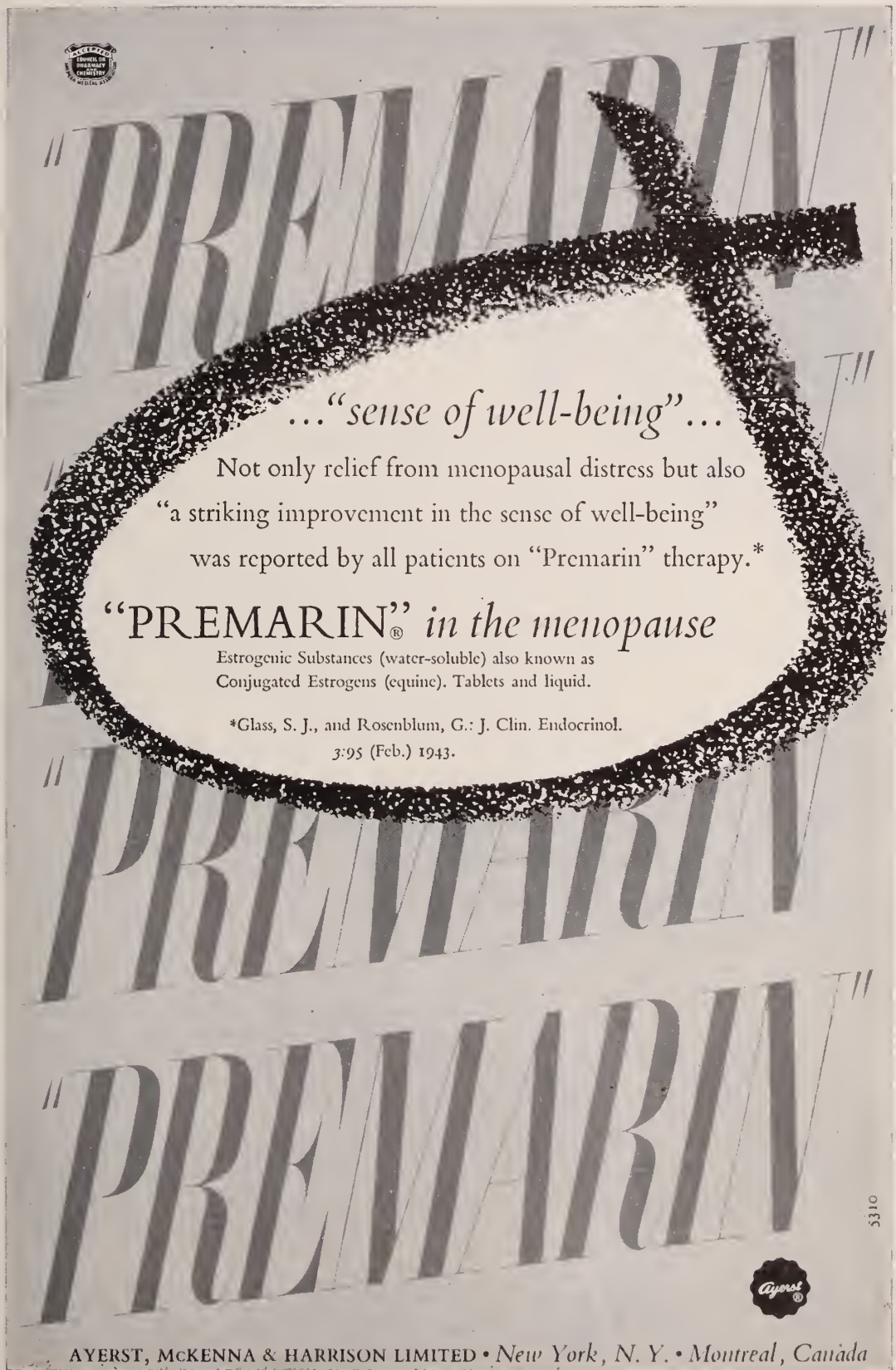
GENERAL FEATURES

Officers and Committees 928
Births and Deaths 937
Medical Officers Returned 937
New Members 938
State News Items 938
Wanted — For Sale 940
Component Society Notes 942
Woman's Auxiliary 944
Books Received 946
Schedule of Meetings 961
List of County Medical Societies, Presidents and Secretaries 962

INDEX TO VOLUME XXXIX 947

This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.


"PREMARIN"
...“sense of well-being”...
Not only relief from menopausal distress but also
“a striking improvement in the sense of well-being”
was reported by all patients on “Premarin” therapy.*
“PREMARIN”® in the menopause
Estrogenic Substances (water-soluble) also known as
Conjugated Estrogens (equine). Tablets and liquid.
*Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol.
3:95 (Feb.) 1943.
5310
Ayerst®
AYERST, McKENNA & HARRISON LIMITED • New York, N. Y. • Montreal, Canada

Therapeutic bile

overcomes stasis

". . . the best bile salt to use . . . would be the one that produced the most copious flow of secretion from the liver. . . . In short, *hydro*choleresis would be advantageous, if achievable.

"It is. The preparation, dehydrocholic acid, commercially available as Decholin . . . does considerably increase the volume output of a bile of relatively high water content and low viscosity. The drug is not a cholagogue, i.e., it does not promote evacuation of the gallbladder, but it is a good 'flusher'."*

Decholin®

dehydrocholic acid, Ames

*Hydro*choleresis with *Decholin* produces abundant, thin, free-flowing bile—"therapeutic bile." This flushes thickened bile, mucus plugs and debris from the biliary tract.

Decholin Tablets, 3¾ gr. (0.25 Gm.), bottles of 100, 500, 1000 and 5000.

Decholin Sodium (sodium dehydrocholate, *Ames*) 20% aqueous solution, ampuls of 3 cc., 5 cc., and 10 cc.

*Beckman, H.: Pharmacology in Clinical Practice, Philadelphia, W. B. Saunders Company, 1952, p. 361.

Decholin and *Decholin Sodium*, trademarks reg.

AMES
COMPANY, INC., ELKHART, INDIANA
Ames Company of Canada, Ltd., Toronto

Some questions about filter cigarettes that may have occurred to you, Doctor

and their answers by the makers of Kent

Q: What materials are used in cigarette filters?

A: Until just recently, cellulose, cotton or crepe paper were the only materials used in cigarette filters.

Now, after long search and countless experiments, KENT's "Micronite"* Filter has been developed. It employs the same filtering material used in atomic energy plants to purify the air of minute radio-active particles.

Q: How effective are these cigarette filters?

A: Scientific measurements have proved that cellulose, cotton or crepe paper filters do not take out a really effective amount of nicotine and tars.

However, these same tests also have proved that KENT's exclusive Micronite Filter *approaches 7 times the efficiency of other filters in the removal of tars and nicotine* and is virtually twice as effective as the next most efficient cigarette filter.

Q: Do physiological reactions to filter cigarettes differ?

A: The drop in skin temperature occurring at the finger tip induced by filtered cigarette smoke was measured according to well-established procedures. (a, b)

For conventional filter cigarettes, the drop was over 6 degrees. For KENT's Micronite Filter, there was no appreciable drop.

Q: Does an effective cigarette filter also remove the flavor?

A: KENT's Micronite Filter . . . the first cigarette filter that really works . . . lets smokers enjoy the full pleasure of a really fine cigarette, yet gives them the greatest protection ever from tars and nicotine.

In less than a year's time, the new KENT has become so popular it outsells brands that have been on the market for years.

• • •

Today, KENTs are sold in most major U.S. cities. If your city is not yet among them, simply write to P. Lorillard Co., 119 West 40th Street, New York, N. Y., and special arrangements will be made to assure you of a regular supply.

References Cited

a. *J.A.M.A.*, Vol. 103, 1934, p. 318
b. *J.A.M.A.*, Vol. 135, 1947, p. 417

* PATENT APPLIED FOR

the PICKER "Century"

it's so *easy to use* ... the automatic "Century" Control *really* monitors operation; relieves you of technical worries.

it's so *dependable* ... identical "Century" settings produce identical results time after time — yesterday, today, tomorrow.

it's so *trouble-free* ... "Century" stamina has been amply proven in the experience of thousands and thousands of users the world over.

it's so *handsome* ... looks as distinguished as it is. Owners are *proud* of their "Centurys".

Definitely the *fine* x-ray unit in the moderate price class ... and so widely esteemed that there are more Picker "Century" 100 ma units actively in use than any other similar apparatus.

Picker X-ray

PICKER X-RAY CORPORATION
25 So. Broadway • White Plains, N. Y.

MIAMI 35, FLA., 2759 Coral Way

JACKSONVILLE, FLA., 1023 Mary Street

read Pfizer Spectrum weekly in the J.A.M.A.

to control fulminating sepsis

Intravenous Terramycin therapy in over 100 cases of surgical sepsis following operations of the thorax, abdomen or limbs gave "none but the most favorable results. The well-known side-effects in connection with orally administered antibiotics . . . were never found to occur, nor did we at any time observe any other toxic reactions."

Deucher, F.: Schweiz. med. Wchnschr. *82*:1 (Jan. 5) 1952.

broad-spectrum

Terramycin Intravenous

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

BRAND OF OXYTETRACYCLINE HYDROCHLORIDE

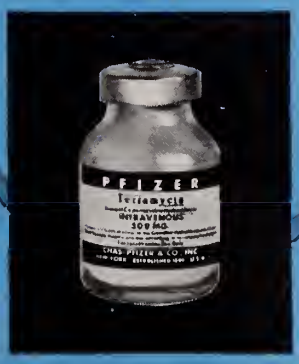
well-tolerated

in infants and children

"Our experience with Terramycin by the intravenous route has been good. It has been effectively used without difficulty by continuous drip infusion for several days in the smallest infant . . ."

Farley, W. J., Konieczny, L.: J. Pediat. *42*:177 (Feb.) 1953.

Vials of 250 mg. and 500 mg



as well as adult patients

Intravenous Terramycin, followed by oral therapy after 3-5 days, "is a singly effective, superior antibiotic in the treatment of peritonitis and . . . a good result can frequently be obtained with this drug when [other antibiotics] have failed. It thus has great usefulness both as a primary therapeutic agent and as an alternate antibiotic."

Reiss, E., et al.: A. M. A. Arch. Surg. *64*:5 (Jan.) 1952.

Pfizer

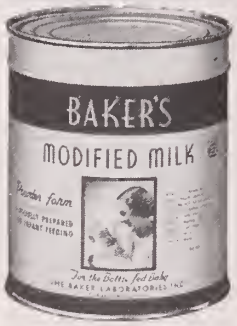
Antibiotic Division
Chas. Pfizer & Co., Inc.
Brooklyn 6, N. Y.

50 YEARS AGO

". . . in all cases where the milk supply is not private and its conditions fully known, all milk for use in the nursery should be boiled immediately upon its arrival in the house. . . . Milk completely sterilized by several exposures to heat . . . and hermetically sealed, will keep sweet for many weeks, and this device is most valuable for long journeys or ocean voyages." (1)

Baker's Modified Milk *Powder* is suggested for baby's safety when traveling. Mother can put the prescribed amount of powder for each feeding in a capped, sterile nursing bottle and carry boiled water in a Thermos bottle. Each feeding can then be prepared just before use.

The powder is also especially adaptable for use wherever refrigeration facilities are not available. Here, too, individual feedings may be mixed as needed.



POWDER and LIQUID

Baker's Modified Milk is made from Grade A Milk (U. S. Public Health Service Milk Code), which has been modified by replacement of the milk fat with animal and vegetable oils and by the addition of carbohydrates, vitamins and iron.

BAKER'S MODIFIED MILK *POWDER FORM*

Simplifies infant feeding when traveling and whenever refrigeration facilities are not available

(1) Cheadle—*Artificial Feeding and Food Disorders of Infants*, Sixth Edition (1906)

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES INC.

Main Office: Cleveland 3, Ohio
Plant: East Troy, Wisconsin

Division Offices: Atlanta, Dallas, Denver, Greensboro, N. C., Los Angeles, San Francisco, Seattle

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

Cortone®

ACETATE

(CORTISONE ACETATE, MERCK)

AND

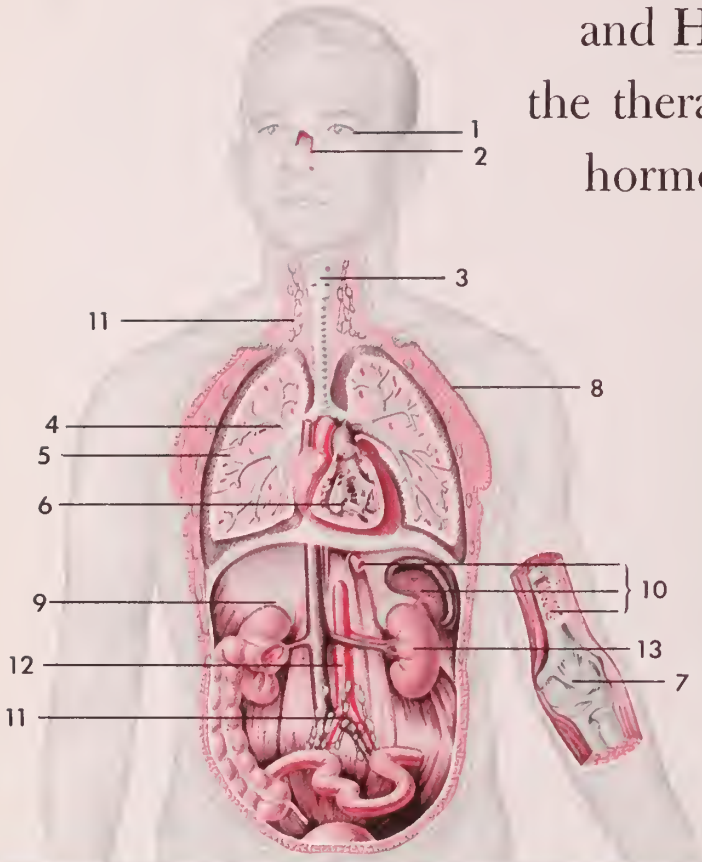
Hydro Cortone®

(HYDROCORTISONE, MERCK)

ALL CORTONE AND HYDROCORTONE TABLETS

CARRY THIS TRADE-MARK

The many indications for CORTONE and HYDROCORTONE highlight the therapeutic importance of these hormones in everyday practice



Primary Sites of Pathology and Indications

1. EYE—Inflammatory eye disease. **2. NOSE**—Intractable hay fever. **3. LARYNX**—Laryngeal edema (allergic). **4. BRONCHI**—Intractable bronchial asthma. **5. LUNG**—Sarcoidosis. **6. HEART**—Acute rheumatic fever with carditis. **7. BONES AND JOINTS**—Rheumatoid arthritis; Rheumatoid spondylitis; Acute gouty arthritis; Still's disease; Psoriatic arthritis. **8. SKIN AND CONNECTIVE TISSUE**—Pemphigus; Exfoliative dermatitis; Atopic dermatitis; Disseminated lupus erythematosus; Scleroderma (early); Dermatomyositis; Poison ivy. **9. ADRENAL GLAND**—Congenital adrenal hyperplasia; Addison's disease; Adrenalectomy for hypertension, Cushing's syndrome, and Neoplastic diseases. **10. BLOOD, BONE MARROW, AND SPLEEN**—Allergic purpura; Acute leukemia† (lymphocytic or granulocytic); Chronic lymphatic leukemia.† **11. LYMPH NODES**—Lymphosarcoma†; Hodgkin's disease.† **12. ARTERIES AND CONNECTIVE TISSUE**—Periarteritis nodosa (early). **13. KIDNEY**—Nephrotic syndrome, without uremia (to induce withdrawal diuresis). **14. VARIOUS TISSUES**—Sarcoidosis; Angioneurotic edema; Drug sensitization; Serum sickness; Waterhouse-Friderichsen syndrome.

† Transient beneficial effects.

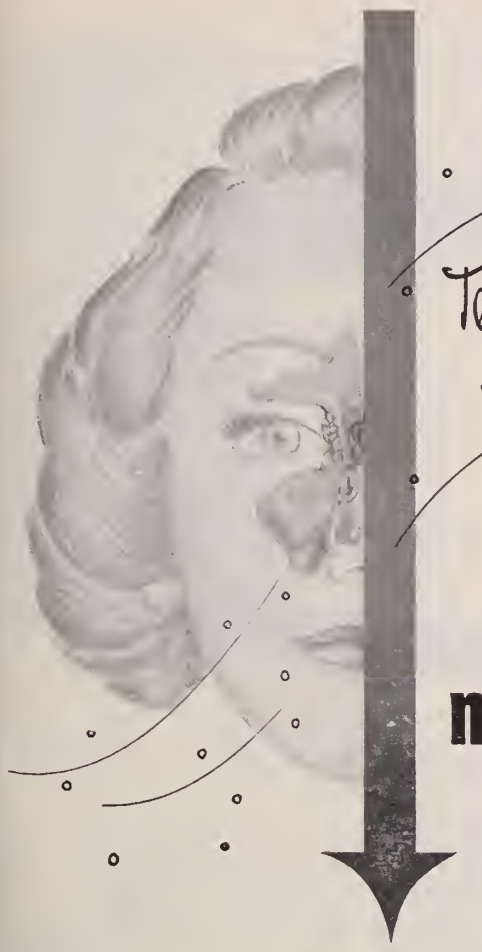
Cortone® ACETATE (CORTISONE ACETATE, MERCK) — ORAL • PARENTERAL • OPHTHALMIC

HydroCortone® (HYDROCORTISONE, MERCK) — ORAL • INTRA-ARTICULAR (HYDROCORTONE Acetate) • TOPICAL (HYDROCORTONE Acet

MERCK & CO., IN
Manufacturing Chemists
RAHWAY, NEW JERSEY

MERCK

CORTONE & HYD
CORTONE re
registered trade-m
of Merck & Co. Inc
its brands of cort
and hydrocorti
respectively. The
stances were first
available to the w
through M
research and produ



To open congested air passages in hay fever

NEO-SYNEPHRINE®

HYDROCHLORIDE

. . . *reduces nasal engorgement* . . .

. . . *promotes aeration . . . encourages drainage*

Supplied in 0.25% solution (plain), bottles of 1 oz., 4 oz. and 16 oz.; 0.25% solution (aromatic), bottles of 1 oz. and 16 oz.; 0.5% solution, bottles of 1 oz.; 1% solution, bottles of 1 oz., 4 oz. and 16 oz.; 0.125 (⅛)% solution, bottles of ½ oz.; 0.5% water soluble jelly, in ⅝ oz. tubes.

A few drops of Neo-Synephrine 0.25% in each nostril will promptly check mucosal engorgement and hypersecretion, promoting greater breathing comfort over a period of several hours.

The resultant relief to the hay fever sufferer is decidedly gratifying. Prolonged action of Neo-Synephrine makes fewer applications necessary, consequently longer periods of rest and sleep are possible.

Neo-Synephrine does not lose its effectiveness on repeated application and may, therefore, be relied upon to give relief throughout the hay fever season.

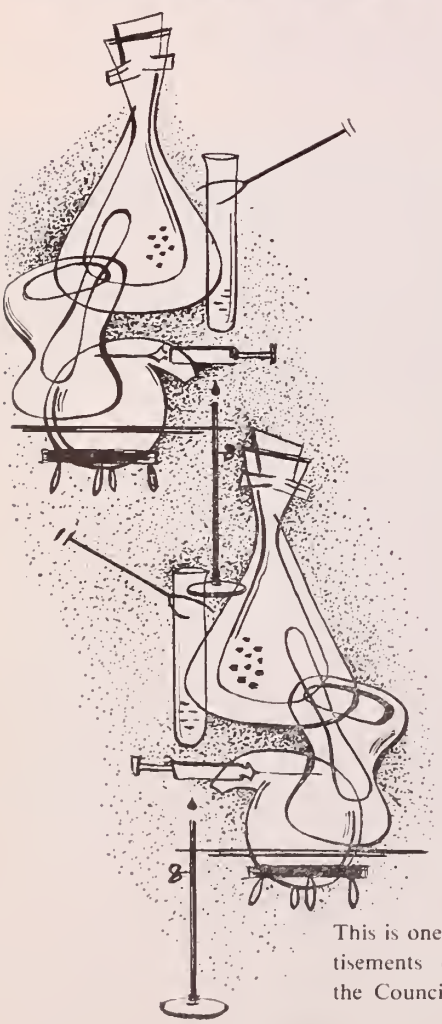
Neo-Synephrine is practically free from sting and compensatory congestion; does not appreciably inhibit ciliary activity. Neo-Synephrine has been found relatively free from systemic side effects such as nervous excitation, cardiac reaction or insomnia even when tested on hypertensive, cardiac and hyperthyroid patients.[1]

1. Von Alyea, O. E., and Donnelly, Allen: Arch. Otolaryng., 49:234, Feb., 1949.

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

Neo-Synephrine, trademark reg. U.S. & Canada, brand of phenylephrine.

What is the status of____?



Many times you have asked yourself, "Is the indicated drug Penicillin . . . Chloramphenicol . . . Aureomycin . . . Sulfadiazine . . . a combination . . . or what?" This same problem may confront you many times . . . not only with the antibiotics—but actually in any specific field where there are numerous drugs . . . and you are faced with the problem of determining which might be the therapy of choice for a given condition.

The need for such clarification has always been apparent to the Council on Pharmacy and Chemistry of the American Medical Association. Its frequent publication of special status reports in THE JOURNAL is designed to help answer such questions for you.

Information about new drugs—clinically proved indications . . . experimental uses . . . correct dosages . . . contra-indications . . . and similar facts—is frequently presented by the Council. Its announcements of newly accepted products also help keep you up-to-date on new and useful drugs. These notices which appear in THE JOURNAL almost every week can be a definite guide to you in knowing what preparations are Council accepted . . . how they are best used . . . and how they can be most effective in your daily practice.

Insistence on Council accepted products is one reliable guide to clinically tested products.

This is one of a series of advertisements designed to explain the Councils' functions to you.

ACCEPTED — COUNCIL ON PHARMACY AND CHEMISTRY — AMERICAN MEDICAL ASSOCIATION

ACCEPTED — COUNCIL ON PHYSICAL MEDICINE AND REHABILITATION — AMERICAN MEDICAL ASSOCIATION

ACCEPTED — COUNCIL ON FOODS AND NUTRITION — AMERICAN MEDICAL ASSOCIATION

ACCEPTED — COMMITTEE ON COSMETICS — AMERICAN MEDICAL ASSOCIATION

cortisone + SCHERING = Cortogen

The symbol SCHERING denotes leadership in steroid hormone research and manufacture -- including Cortogen in the most useful clinical forms. For systemic therapy, use Cortogen tablets SCHERING or injection. For eye disorders use Cortogen ophthalmic suspension -- sterile. The Schering seal SCHERING appears on each tablet and package -- your assurance of quality.

CORTOGEN®

Acetate (cortisone acetate, Schering) Tablets, 5 mg. and 25 mg.;
Injection, 25 mg. per cc., 10 cc. multiple-dose vials;
Ophthalmic Suspension—*Sterile*, 0.5% and 2.5%, 5 cc. dropper bottles.

Schering CORPORATION · BLOOMFIELD, NEW JERSEY
In Canada: Schering Corporation, Ltd., Montreal.

CORTOGEN

SCHERING

Volume XXXIX
Number 12

antibiotics . . .

USE ERYTHROCIN*

...especially effective against gram-positive organisms including those resistant to penicillin and the other antibiotics.

USE ERYTHROCIN*

. . . has low toxicity; orally effective against infections caused by staphylococci, streptococci and pneumococci.

USE ERYTHROCIN*

. . . indicated in pharyngitis, tonsillitis, scarlet fever, pneumonia, erysipelas, osteomyelitis and pyoderma.

USE ERYTHROCIN*

...gastrointestinal disturbances mild and relatively rare; no serious side effects reported.

USE ERYTHROCIN*

. . . fully potent; average adult daily dose 0.8 to 2.0 Gm., depending on type, severity of infection.

USE ERYTHROCIN*

...special absorption-favoring coating; 0.1 Gm. (100 mg.) tablets supplied in bottles of 25 and 100. Abbott

* *Trade Mark for*
ERYTHROMYCIN, ABBOTT

1-178

SUPERMIX liquid chemicals are 6 ways better than powders

Read why 83% of GE's customers have switched to liquids

EVERY PROCESSOR WANTS THESE	HOW SUPERMIX LIQUID CHEMICALS GIVE YOU THESE ADVANTAGES
1 BETTER FILMS	SUPERMIX Developer brings out every bit of contrast, density and detail that are in the film. And, with proper refreshing, it will do it in the same time month after month.
2 MORE FILMS	Using SUPERMIX liquid chemicals, you can process nearly twice the number of films possible with powders in a given time. That means you can handle a much greater film load without interruption.
3 FASTER PROCESSING	Fresh SUPERMIX Developer works in 3 minutes. Fresh SUPERMIX Fixer clears in 45 seconds — films are ready for wet-film viewing in 4 minutes — completely developed and fixed in 5.
4 LESS WORK	No pails, pans, paddles, thermometers or screwdrivers! Just pour SUPERMIX into the tank, add water at working temperature — and you're all set. No overnight wait.
5 EXTREME STABILITY	SUPERMIX Developer, Refresher and Speed Fixer have withstood tests in temperatures as low as 75° below zero . . . as high as 155° F for 30 consecutive days—without damage.
6 LOWER COSTS	The long life and increased output of SUPERMIX liquid chemicals save you money. Using Refresher, you can process 1200 14 x 17's in SUPERMIX for a cost of *only 3.7¢ each!*

Ask your GE x-ray representative for a copy of our informative booklet, "A Look at X-Ray Film Processing," or write:

You can put your confidence in —

GENERAL ELECTRIC

Direct Factory Branches:

JACKSONVILLE — 210 W. Eighth St.
TAMPA — 1009 West Platt St.
MIAMI — 704 S.W. 27th Ave.
BIRMINGHAM — 707 21st St., South

Upjohn

long-acting
androgen:

Depo-Testosterone

Trademark Reg. U.S. Pat. Off.

CYCLOPENTYLPROPIONATE

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Each cc. contains:

Testosterone Cyclopentylpropionate .....50 mg. or 100 mg.
Chlorobutanol ..... 5 mg.
Cottonseed Oil .....q.s.

50 mg. per cc. available in 10 cc. vials

100 mg. per cc. available in 1 cc. and 10 cc. vials

The Upjohn Company, Kalamazoo, Michigan

Mild

Cool

Flavorful

There must
be a reason why...

More people smoke

Camels

than any other
cigarette!

Upper Left Quadrant of the Abdomen

1 Diaphragm and coronary ligament
2 Falciform ligament
3 Hepatic veins
4 Inferior vena cava and right vagus nerve
5 Crus of diaphragm and abdominal aorta
6 Celiac artery and celiac plexus
7 Hepatic artery and portal vein
8 Gastroduodenal artery and vein
9 Subpylorie lymph nodes
10 Duodenum
11 Superior panereaticoduodenal artery and vein
12 Right gastroepiploie artery and vein
13 Superior mesenteric artery and vein
14 Superior mesenteric lymph nodes
15 Transverse colon and right eolie artery and vein
16 Spermatic artery and vein
17 Left triangular ligament and left lobe of liver
18 Esophagus and left vagus nerve
19 Paraeardial lymph nodes
20 Esophageal branch of left gastric artery and vein
21 Gastric rami of vagus nerve
22 Splenic lymph nodes
23 Left gastric artery and coronary vein
24 Spleen and splenic artery and vein
25 Superior pancreatic lymph nodes
26 Pancreas and tenth rib
27 Left gastroepiploie artery and vein
28 Left kidney
29 Inferior gastric lymph nodes
30 Jejunum
31 Descending colon
32 Ileocolic artery and vein

This is one of a series of paintings for Lederle by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.

Lederle

In peritonitis,
in intestinal infections,
and as a prophylactic adjunct
in surgery of the bowel—

Aureomycin

HYDROCHLORIDE CRYSTALLINE

provides an unsurpassed
range of antimicrobial action

Literature available on request

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.

New Horizons in Antibiotic Therapy

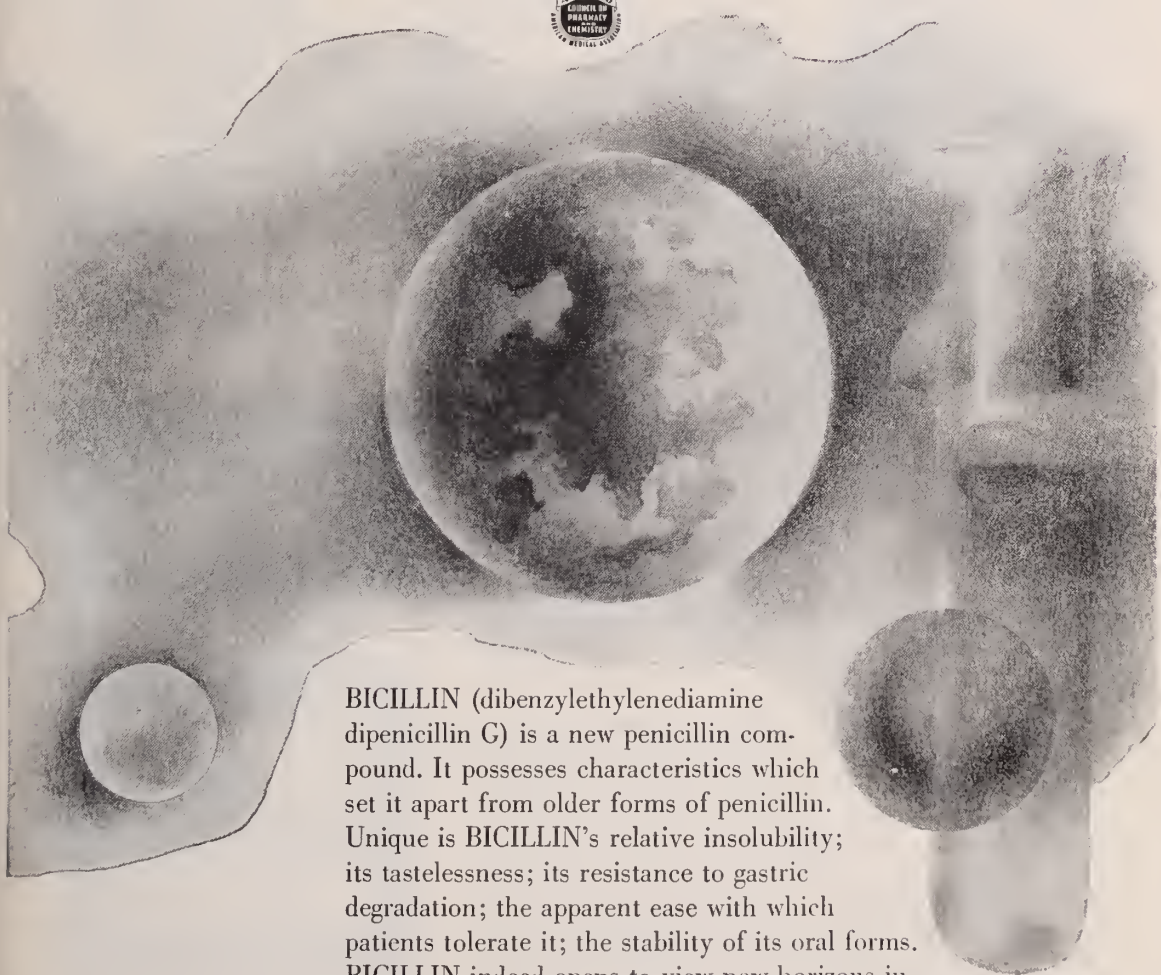
BICILLIN®

Dibenzylethylenediamine Dipenicillin G

A NEW FORM OF PENICILLIN

***NOW*... Council Accepted**

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION



BICILLIN (dibenzylethylenediamine dipenicillin G) is a new penicillin compound. It possesses characteristics which set it apart from older forms of penicillin. Unique is BICILLIN's relative insolubility; its tastelessness; its resistance to gastric degradation; the apparent ease with which patients tolerate it; the stability of its oral forms. BICILLIN indeed opens to view new horizons in antibiotic therapy . . . new applications of penicillin—drug of choice in a wide range of infections.

BICILLIN is available in oral suspension, tablet and injectable forms

Wyeth® Philadelphia 2, Pa.

If this doesn't work—maybe we'd better

call the MEDICAL SUPPLY MAN!"

But—if there's any question about instruments or equipment—wouldn't it be a much better idea to call the Medical Supply Man right now?

Normally, Medical Supply Company carries more than 15,000 individual items in stock—instruments, equipment and supplies—just waiting for your call. In addition, we have experienced service men who can put stubborn equipment back in shape in jig time,

So, don't take chances with "make do" equipment or supplies. Obey that impulse now—and CALL THE MEDICAL SUPPLY MAN!

HOSPITAL, PHYSICIANS and LABORATORY SUPPLIES & EQUIPMENT

MEDICAL SUPPLY COMPANY

Essentials For Scientific Progress

MIAMI • of JACKSONVILLE • ORLANDO

230 N. E. THIRD ST.
MIAMI 32, FLA.

420 WEST MONROE ST.
JACKSONVILLE 2, FLA.

329 N. ORANGE AVE.
ORLANDO, FLA.

E. R. SQUIBB & SONS 745 FIFTH AVENUE, NEW YORK 22, NEW YORK

Dear Doctor:

Usually Inadequate

℞

Tolserol Tabs. 0.5 gram

Disp. #100

Sig: One tablet 3 to 5 times a day. Take after meals or with 1/3 glass of milk.

This prescription is typical of many written for Tolserol Tablets*, as seen in a recent prescription survey.

Although some patients will respond to such low dosage, much better results can be obtained by following the recommended dosage: 1 to 3 grams, 3 to 5 times per day.

In accordance with this recommendation, the first dosage schedule for a patient could be:

Better

℞

Tolserol Tabs. 0.5 gram

Disp. #100

Sig: Two tablets 3 to 5 times a day. Take after meals or with 1/3 glass of milk.

Complete information on the use of Tolserol in muscle spasm of rheumatic disorders, neurologic disorders, and acute alcoholism is available from your Squibb Professional Service Representative.

Sincerely yours,

L. H. Ashe

L. H. Ashe, Manager
Professional Service Dept.

•TOLSEROL• IS A REGISTERED TRADEMARK

*Squibb 'Mephenesin'

Memo

Re: Digitalization

Unless the situation is very urgent, it is usual to give 0.6 mg. of 'Crystodigin' by mouth, to be followed by 0.4 mg. every 6, 12, or 24 hours until a full effect is obtained --usually within 2 or 3 days. The total dose will seldom exceed 1.8 mg. Then the dosage can be reduced to the maintenance level.

For maintenance, patients' requirements vary. As little as 0.05 mg. is sufficient in some cases. The usual case requires 0.1 mg. More rarely, 0.2 mg. or slightly more will be required.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

'Crystodigin' is available in 0.05-mg., 0.1-mg., 0.15-mg., and 0.2-mg. tablets. Ampoules containing 0.2 mg. per cc. are available in 1-cc. and in 10-cc. (rubber-stoppered) ampoules.

'Crystodigin'

(CRYSTALLINE DIGITOXIN, LILLY)

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXIX | Jacksonville, Florida, June, 1953 | No. 12

President's Address

ROBERT B. MCIVER, M.D.
JACKSONVILLE

What a heartening experience it has been to serve the Florida Medical Association in key official positions these last ten years. You honored me with the office of Secretary-Treasurer for eight years and with that of President-elect for one year before conferring upon me the presidency. As I relinquish this highest office, I reflect with gratitude and deep satisfaction upon the contacts and experiences of office which have immeasurably enriched my life. My appreciation of the confidence you have placed in me is equaled only by my regret that the modicum of service I have rendered has been far from commensurate with my desire to serve you.

The success of any president lies largely with his official family, as my experience in this office attests. On behalf of the Association and of myself, I express appreciation to the officers serving with me during the year and to the Board of Governors for their wholehearted cooperation and unselfish service. To the chairmen and members of the numerous committees we are all likewise indebted for their participation in promoting the year's program. The progress attained during my administration is mostly the measure of their official efforts and their sacrifices.

The Executive Office

How many of you have ever visited your Association's headquarters? To do so is to perceive the detailed organization and remarkably efficient operation of the Executive Office, and to come away marveling at how it is possible to get so much for so modest an investment. Few of us have even a remote conception of the tremendous volume of business expertly handled there at a surprisingly low financial outlay.

The Association has been blessed for more than a quarter of a century with a Managing Director endowed with the wisdom, the insight and the experience which enabled him to enrich its life and expedite its progress from year to year. Most of us were privileged to know Stewart Thompson. And to know him was to love him, for his warmth and kindliness of spirit endeared him to all. Working closely with him and his staff was both an education and a major delight of the presidency. In him was found both inspiration and wise counsel, both uncanny organizational ability and unswerving loyalty, as my predecessors will confirm. When on yesterday we observed one minute of silence as a final tribute to our fallen friend and guide, I was poignantly reminded, as I am sure we all were, that to him we owe an everlasting debt of gratitude.

Growth

By action of the House of Delegates in 1951, the annual joint report of the Secretary-Treasurer and the Managing Director is no longer read at a general session of the Annual Meeting. I should, therefore, be remiss indeed not to sound a progress note here. Certainly I urge every member to read the report in the June Journal. From a score of charter members 79 years ago, the membership of your Association has grown to 2,415 for the year closing on March 20, 1953. This figure is the highest on record.

Today, the Association is strong and steady. It commands high regard throughout the nation. To what may its phenomenal progress across the years be attributed? It has gained a dominant position through the guidance of a long succession of medical leaders selected consistently on the basis of ability and devotion to their profession, and also through the willingness of the component soci-

Read before the Florida Medical Association, Seventy-Ninth Annual Meeting, Hollywood, April 28, 1953.

eties to keep local aspirations in their proper perspective. This wise leadership, piloted in the more recent years of greatest growth by the sure hand of the Managing Director, together with the cooperation of the membership has led your state society out into the large place it now occupies.

The Official Publication

Let me urge you to read, also in the June issue of The Journal, this year's report of the Editor. The high rating of your publication among state journals reflects favorably on those members who are contributors. To say that The Journal is as good as its Editors is also to say that it is only as good as the material the members provide for their utilization.

The quality of its scientific articles is a gage of professional progress which, above all, determines its rating as a medical periodical. Requests for reprints from throughout the nation and from many foreign countries attest the high quality of this important department. The unique editorial features and the comprehensive abstract section also merit special commendation. Every member can make some contribution, if only a news item. Too, all can peruse The Journal carefully enough to offer, at the least, a word of commendation or a bit of constructive criticism aimed at increasing its useful mission. Any such manifestations of interest would serve the Association and be welcomed by the veteran Editor, the Assistant Editors, the Associate Editors and the Committee on Publication. After all, The Journal is your journal.

A.M.A. Delegates

The Association has every reason to be proud of its representation in the House of Delegates of the American Medical Association. At the meeting of that body last June, Dr. Homer L. Pearson, Jr., of Miami, long a delegate until this year, was elected to succeed himself as a member of the Judicial Council for a term of five years. As of Jan. 1, 1953, the Association became entitled to but two delegates since the apportionment now in effect is one delegate for each 1,000, or fraction thereof, active members of the American Medical Association. Last year, the membership on which representation was determined was 2,007, and the able representatives were Drs. Pearson, Louis M. Orr II and Herbert L. Bryans. This year, a membership of 1,983 makes one less delegate mandatory.

Legislative Committee

With the legislature in session this spring, the Committee on Legislation and Public Policy has had a particularly heavy task this year, which it has performed with distinction. It affords me pleasure to make mention of the valuable service of Dr. Eugene G. Peek, Sr., of Ocala during the years he served as Chairman of this Committee. When he declined that responsibility for a further period and it became my duty to appoint a successor, I turned intentionally to a young man. Already, Dr. H. Phillip Hampton of Tampa has proved the wisdom of my choice. It is my earnest hope that he may serve the Association long and well in this important capacity. The talents of our younger members are an asset which we should utilize ever more widely.

Much as I should like to commend the various Committees individually, I shall mention in addition only two others at this time, a Subcommittee and a special Committee.

Fee Schedule Committee

To Dr. John D. Milton, Chairman, and the Subcommittee to the Board of Governors on Review of Fee Schedules I desire to offer a personal word of appreciation in addition to the commendation expressed in the report of the Board of Governors. They are to be congratulated on the successful consummation of their difficult task, which required much effort and extensive travel, involving unusual expense and sacrifice of time. Those members of the Association who are now receiving the benefits of more equitable fees in veterans' care, workmen's compensation and Blue Shield cases are enjoying the fruits of their unremitting toil.

Special Committee

Specialty groups and county medical societies were well represented at an open forum held in Orlando in December for the purpose of discussing the advisability of establishing sections of the Association to replace the independent specialty groups. After the representatives had expressed the wishes of the members of their respective societies, the Special Committee on Scientific Assembly and Specialty Group Problem, of which Dr. Herbert E. White of St. Augustine is Chairman, met to evaluate the problem in the light of the views expressed.

It was recommended that no change be made. The consensus was that the specialty group meetings immediately preceding the annual convention

spark its initial meetings, that some who do not remain throughout the meeting go home to enable their colleagues to attend the remaining sessions, and that two or more scientific sessions meeting simultaneously would create greater dissatisfaction than the current arrangement. Every effort is made to schedule the scientific and business sessions as well as other features of our Annual Meeting so that they will attract the largest attendance and benefit the greatest number.

Our Ship of State

To me, the Florida Medical Association is like a mighty ship that has braved the seas for more than three quarters of a century; it is Florida medicine's great ship of state. In the powerful fleet of American Medicine, its battle station between the surging tides of the Atlantic and the balmy waters of the Gulf is both strategic and unique. In fair weather and foul, our seaworthy vessel plows a steady course ahead. Its keel represents the great principles that across the years have kept it afloat. To preserve the ideals of the medical profession, to seek its honor, to uphold its highest traditions, to maintain ethical standards, to raise ever higher the educational requirements for those who would join its ranks, to defend its rights and privileges, these are the sturdy timbers of its frame.

On this keel a succession of far seeing and self-sacrificing leaders have laid the superstructure. In the deliberations and decisions of the House of Delegates, innumerable committees have caulked its joints and held them firm. All have labored to the end that the profession may give an ever more perfect service to the people.

The passengers on this ship are the members of our Association. Looking back upon the ever growing passenger list of those who have made the voyage before us, we who promenade the decks today know that ours is a great heritage. And as we look backward, let us go forward. We must follow in the footsteps of our illustrious predecessors. A deep obligation rests upon us to make a worthy contribution in our time, and likewise to transmit our noble heritage to those who come after us.

Too much emphasis cannot be placed upon the importance of the individual passenger on our ship — the physician actuated by the thought that the practice of medicine is a vocation, not a business. In the last analysis, the doctor is the determining factor of the worthwhileness of the whole system of the care of the sick. It is he who is the sine qua non.

Public Relations

Take public relations, for example. Our dignity, our future, our freedom to give our fellow men the high service to which they are entitled depend upon our efforts and our ability to retain the love and respect of the people. Here we erect our greatest bulwarks against regimentation. Who but the physician himself can keep these bulwarks of our ship in trim? Every doctor obviously is a public relations man for the whole medical profession. He cannot escape this role.

As with the sulfonamides and the antibiotics, medical public relations has now been on trial long enough for its true pattern of usefulness to be relatively well determined. Their short and tempestuous experience in public relations on a large scale has demonstrated to men of medicine the pitfalls and boomerangs they may ever expect to encounter in this alien environment. Into it they were rudely thrust, and from it there seems to be little or no likelihood of future escape.

Two facts are manifest. The first is that the handling of this important aspect of the Association's work cannot be delegated wholly to employed lay personnel and dismissed forthwith. The Bureau of Public Relations is invaluable and its staff indispensable as aides, but inevitably we must be our own ambassadors of good will. Astute, well trained representatives from the Executive Office stand ready at all times to lend all possible assistance. They welcome the opportunity to render initial aid in setting up a program and, when needed, will visit any county society to advise on a local program. In general, they lend a helping hand. Nevertheless, no matter how comprehensive their program and how extended their indoctrination in the fine points of ethical medical public relations as viewed from within the profession, the role of lay personnel is a subsidiary one.

The second fundamental is that medical public relations has leveled off at the grass roots. It is primarily a local matter. Although at first it pyramided to top levels in a big way, in due time it boomeranged back to the true level of the individual county society and its individual members. Essentially, it is what they make it.

As I have reminded the several county societies I have been privileged to address this year, people are not particularly interested in doctors as a group. About their own doctors, however, they are vitally concerned. The safe, sure road to

amicable relations with the public lies in recognition, acceptance and application of this basic factor. In instances too numerous to recount, it has been remarkable what some county societies have accomplished through the enthusiasm, ingenuity and hard work of their members.

Did you read "The Medical Forum Story?" This brochure was mailed to every member early in March. Here is a case in point — an excellent example of public relations at its best at the grass roots level. Known in medical circles as the "Pinellas Plan," the Medical Forum is an educational project sponsored by the Pinellas County Medical Society and the St. Petersburg Times. It has attracted nation-wide attention in lay and medical publications and has brought inquiries from all over the country. Originating from an interview between Dr. N. Worth Gable of St. Petersburg and Stan Witwer, city editor of The Times, the unique public relations project owes its success to keen public interest promoted by aggressive newspaper support and the wholehearted cooperation of the Pinellas County Medical Society. It promises to become as popular as the fair exhibits, another notable Florida contribution to public relations.

As Chairman of the Board of Governors, I would like to present an item considered by the Board which was not included in the annual report as published in the Handbook for Members of the House of Delegates. I strongly urge that favorable consideration be given to the Board's recommendation to disband the regular Committee on Public Relations and that the Board designate one of its members as liaison for public relations between the Board and the Executive Office.

Under this plan the Board of Governors will pass on all major policies. This proposed change in the directing of public relations is not to be considered as any reflection on current or previous committees. They are to be complimented for having given generously of their time and talents in this constantly developing and ever changing phase of the Association's activities. The problems, however, are of such nature and so involved as to make this appear to be a more satisfactory plan.

During 1952, the American Medical Association disbanded its public relations committee and transferred the activities and problems thereof to the executive committee of the board of trustees.

Centennial of Oldest Component Society

With your indulgence, I wish to congratulate my own county society on the occasion of its one hundredth anniversary. Antedating the Florida Medical Association by 21 years, the Duval County Medical Society is the oldest in the state. It was organized in Jacksonville on May 19, 1853, and remained the only one in Florida until well after the War Between the States. In November 1873 a call went out from this society to the half dozen recently organized county medical societies and to individual members of the profession throughout the state which resulted in the founding of the Florida Medical Association in Jacksonville on Jan. 14, 1874. The organization meeting was held in the home and office of Dr. A. S. Baldwin, who had been largely instrumental in founding the Duval County Medical Society two decades earlier. On motion of Dr. Baldwin, your Association came into being under the title of "The Medical Association of the State of Florida," and Dr. Baldwin became the first president.

Today, the Duval County Medical Society is not only the oldest component county society, the second largest and the one responsible for the founding of this Association, but it is also the first to have a home of its own. It alone of the 36 county societies is housed in a building devoted exclusively to its use and after nearly four years of occupancy, it now plans an addition. The success of this venture should encourage other component societies, some of which have long planned and even established a sinking fund for such a project.

On Guard

During the 34 years that I have been a passenger on our ship of state, with the exception of the first year and one other, I have been privileged to serve in some official capacity, however minor. In my time I have sailed on smooth and sparkling waters and I have also ridden out a hurricane or two. In this year of my presidency alone, I have traveled in your behalf 5,917 miles within the state and 5,204 miles beyond its borders. As I have journeyed hither and yon, my observations have led me to one paramount conclusion — now is no time for complacency. After the recent tempestuous storms, misinterpretation of the present lull could easily be disastrous. In the battle with socialism we have but won a skirmish, a mere patrol action that admits of no lowering of the guard. Preening ourselves proudly in

smug self satisfaction is no way to protect our heritage and preserve our freedom. Our responsibility here, I fear, is far heavier than we realize.

True enough, when the forces of socialism came yapping at our heels, we put up a remarkably solid front. The unity of purpose and the aggressive action against regimentation manifested by all, from national leaders down to the least of the county societies, are not only a matter of just pride but far more. The future depends upon how well we have learned the lesson they taught. A medical profession strongly organized, united in an unceasing effort to perfect its services to the people, and standing foursquare against the common enemy in the interest of freedom for all, cannot fail to command respect and confidence. Always, however, the watchwords must be harmony, teamwork and eternal vigilance.

Tomorrow another takes over the helm of our ship. As I retire to become the twenty-fourth member of your Board of Past Presidents, I would leave with you Longfellow's familiar lines, penned with our great nation in mind but, to me, applicable as well to our Association:

> Thou, too, sail on, O Ship of State! . . .
> Sail on, nor fear to breast the sea!
> Our hearts, our hopes, are all with thee,
> Our hearts, our hopes, our prayers, our tears,
> Our faith triumphant o'er our fears,
> Are all with thee, — are all with thee!
>
> The Building of the Ship
> Henry Wadsworth Longfellow

ABSTRACTS OF MEDICAL ARTICLES

Effect of Hyaluronidase on Urine and Its Possible Significance in Renal Lithiasis. By Arthur J. Butt, M.D., Ernst A. Hauser, Ph.D., and Joseph Seifter, M.D. J. A. M. A. 150:1096-1098 (Nov. 15) 1952.

It is here reported that subcutaneous injection of hyaluronidase, mixed with sotonic sodium chloride solution, pronouncedly increases the protective urinary colloids and causes clearing of turbidity and sediment in the urine of the majority of persons studied. Methods of determining protective urinary colloids are outlined, and a regimen of hyaluronidase therapy for patients subject to renal lithiasis is presented. The dosage of hyaluronidase varies from 150 to 900 turbidity reducing units every 24 to 48 hours. Hyaluronidase therapy was effective in preventing calculous formation or reformation during a period of 11 to 21 months in 19 of 24 patients, 79 per cent, in whom kidney stones previously formed at a rapid rate.

A Subnormal Response to Cream in Cancer Patients. By Jerome M. Waldron, M.D., Barkley Beidleman, M.D., and Garfield G. Duncan, M. D. Cancer 5:583-586 (May) 1952.

Observing that an increased coagulability of the blood after the ingestion of cream occurs normally and that cream also has in vitro clot-accelerating properties, the authors report a study of 230 patients, a small group of whom showed a subnormal response to the in vivo clot-accelerating properties of cream. The only common factor in this group was the presence of cancer. The occurrence of this subnormal response is independent of the type or site of cancer. It is also independent of certain factors common to cancer patients, such as elevated sedimentation rate, level of plasma protein, and state of nutrition. Since the mechanism of the clot-accelerating properties of fat in normal patients is not known, the reason for the lack of response in cancer patients cannot be explained at this time.

Palliative Treatment of Prostatic Cancer. By James B. Glanton, M.D., Raymond J. Fitzpatrick, M.D., Louis M. Orr., M.D., and Joseph C. Hayward, M.D. South. M. J. 45:1094-1098 (Nov.) 1952.

The authors state that cancer of the prostate is considered the commonest malignant disease occurring in men after the age of 60 and that it probably occurs in 20 per cent of all men past that age. The cause, they add, is unknown although it would certainly appear to be the result of some chemical or hormonal imbalance.

They have observed some 500 cases of inoperable cancer of the prostate from 1938 to 1948 and suggest the following palliative treatment for obtaining maximum comfort and possible increase in the survival time:

1. Immediate castration and institution of estrogen in its minimal effective dosage.

2. Relief of vesical neck obstruction by endoscopic resection.

3. Androgens may be used to advantage in some cases when estrogen refractiveness or relapse is encountered.

4. Progesterone may at times be used satisfactorily when a poor response to estrogen is observed.

5. Last and most important, general medical supportive measures, which are most necessary in this age group and may be a major factor in further increasing the survival time.

Surgical Correction of Funnel Chest. By F. Gordon King, M.D. Ann. Surg. 136:798-810 (Nov.) 1952.

Observing that funnel chest is a congenital and developmental condition in which surgical therapy may be particularly gratifying, Dr. King reports 6 cases of surgically treated funnel chest deformity, all with excellent results, no serious complications and no residuals. The period of observation covered two to four years, and there was no indication that recurrence was likely. Three additional cases augmented the original series before publication of the report, and in these the results were likewise good.

In 1 case, scoliosis was remarkably improved coincidentally with correction of the funnel chest deformity.

The substernal ligament did not seem to be an important factor in these cases. Etiology is discussed since it may alter the type of surgery required in various cases.

The extreme hazard of tension pneumothorax and the mechanism of its production peculiar to these cases are pointed out. Tight closure of the skin, which will prevent air being pulled into the mediastinum during respiration, is the means of avoiding this complication.

Surgical Methods and Results in the Management of Intractable Esophageal Achalasia. By Herbert R. Hawthorne, M.D., and H. Clinton Davis, M.D. Delaware State M. J. 24:306-312 (Nov.) 1952.

Achalasia, megaesophagus, cardiospasm, and idiopathic dilatation of the esophagus are terms commonly applied to a condition in which the cardiac sphincter does not relax effectively during deglutition. While the results of conservative therapy for this functional disturbance are usually gratifying, surgical treatment is required in a small but significant percentage of cases when dilations, psychotherapy, antispasmotics and special diets fail to bring relief. It is the purpose of this article to discuss the surgical methods and their results with special reference to esophagogastrostomy and esophagocardiomyotomy in a personal, well followed series.

In summary, the authors state that a trial of dilatations and medical therapy is indicated in view of the good results obtained in the majority of cases. Also, associated visceral pathology may be found to be an aggravating influence in a surprising number of cases. In their opinion, surgery should be reserved for those cases in which there is no response to conservative treatment and for the small group of cases in which malignant disease cannot be ruled out. Their experience in 14 cases of intractable achalasia, in which treatment consisted of esophagogastrostomy or esophagocardiomyotomy, demonstrated that the late results with the latter technic are superior.

PROCEEDINGS
Seventy-Ninth Annual Meeting

of the

FLORIDA MEDICAL ASSOCIATION

Held at HOLLYWOOD

APRIL 27, 28 and 29, 1953

GENERAL SESSIONS

First General Session

The Seventy-Ninth Annual Meeting of the Florida Medical Association was called to order at 9:40 a.m., Monday, April 27, in the Mardi Gras Room of the Hollywood Beach Hotel, Hollywood, Fla., by President Robert B. McIver.

Invocation was pronounced by The Reverend C. C. Frazier, Pastor, Hollywood Methodist Temple, Hollywood.

Dr. McIver: "Dr. V. Marklin Johnson of West Palm Beach will deliver the address of welcome."

Dr. Johnson: "President McIver, Members of the Association and Guests, I am happy that our president has accorded me the privilege of welcoming you to this, the seventy-ninth annual session of the Florida Medical Association.

"We have returned to the Hollywood Beach Hotel because of its excellent service and convention facilities. You will find that a number of improvements have been made since the time of our last meeting and that these will add materially to our comfort in both group meetings and general assemblies.

"It is my understanding that this is not to be a key-note-type of address, and I am sure that no Chamber of Commerce tactics are necessary in a meeting of this sort. I am also certain that the charms, the attractions, the advantages, and the developments of Southeast Florida are common knowledge to you all. Nevertheless, if you do find it difficult to spend your time or your money or feel it necessary to seek out some special brand of entertainment other than that to be furnished by the committee, I am sure that the members from the Southeast district will be glad to impart to you the necessary information.

"In a more serious vein, it might be said that we come to these annual meetings for reasons which may be termed social, economical, political and educational.

"Socially, we hope to see again our old friends and to make new ones. Our Association has grown so in the past decade that many of our old timers find it difficult to keep up with the new faces. Let us all try to know each other better.

"Medical economics and public relations are today recognized as subjects of major importance to the medical profession. Much credit is due our members in Pinellas County for their excellent leadership in the creation of the Public Medical Forum and the resultant favorable public reaction. Many county societies are doing a fine public relations job. Just lately, the Dade County Medical Association has joined the medical forum ranks.

"Politically, it may be said that the medical profession won a victory last November. President Eisenhower and many members of the party now in power have declared themselves opposed to socialized medicine. Let us not, however, drop our guard and assume a sense of false security, but remember that the proponents of socialized medicine are still very much alive and will forever be attempting to pass legislation which may some day lead to the very thing which we fought so hard to prevent. It would seem that now is the time when we should exert ourselves to the utmost, to create and prepare a program, so constructive and so sound, that the majority of the American public will insist upon its adoption.

"The Committee on Scientific Work has provided us with a group of excellent and diversified papers which should prove most informative.

"Only a few days ago, many of us were shocked to learn of the death of an old and faithful friend, a tireless worker for this Association. His passing is enough to dim the tempo of any meeting. Yet, I am sure that Stewart Thompson would want but one thing from us, that we carry on with the same spirit which he so well exemplified.

"Again let me extend to you the best wishes of the Association for a most enjoyable meeting."

Dr. McIver: "I would like to recognize the fraternal delegates from other states. Will you please stand as your name is called? Dr. George R. Dillinger, Thomasville, Ga.; Dr. Joyce F. Mixson, Jr., Valdosta, Ga.; Dr. J. A. Leaphart of Jesup, Ga.

Dr. Mixson was present and acknowledged the recognition.

Dr. McIver: "We appreciate very much your coming down here to represent your state, in this extension of your state. We have three delegates who are going to your meeting in Savannah. They have accepted, and I think they are all graduates of Georgia schools."

"I would like to present to you one of my old, personal friends, who is President of the American Urological Association, Dr. George Cahill of New York City."

Dr. Cahill stood to acknowledge the recognition.

Dr. McIver: "Before I call for announcements, I think it is only fitting that we make some special reference to the passing of Stewart Thompson. I would like to report to you that on Monday a week ago, Stewart completed the final details of arrangements for this meeting, even to the budget. In the last 10 or 12 years, I have never known the budget to be completed two weeks before the opening of the Annual Session. On Tuesday, he was so happy about having everything completed that he played golf. His partners in the game reported he said he never felt better. Upon returning home, he retired and shortly after midnight was found to be unconscious and was rushed to the hospital. He remained unconscious. He had a massive cerebral hemorrhage, never regained consciousness, lasted about 10 days and then died.

"Your Association officers took care of the proper recognition while he was still living and have sent in your name a blanket of roses to cover the casket. Services will be conducted this morning at 10:30 in the Kyle Chapel, Jacksonville, and interment will be in Jacksonville. As he would have said — as he did say in one of his last communications to the Board of Governors — 'the hands drop off, but the work goes on'. As he would have wished it, the entire personnel of your state office is here. Each one has his assigned duties and each one is performing them. All of your officers and your incoming officers are here. We have delegated some of those who could not come to represent us at the services this morning. They have been officially notified by communication and copies have been sent to his widow and his daughter."

Dr. McIver recognized Dr. Russell B. Carson who made an announcement about the Smoker.

Dr. McIver: "In 34 years, I have never seen such a turn-out at the opening session. I think this is a tribute to Stewart Thompson."

There being no further business, the meeting adjourned on motion, duly seconded, at 9:55 a.m.

Second General Session

The Second General Session of the Florida Medical Association convened at 11:30 a.m., Tuesday, April 28, in the Mardi Gras Room of the Hollywood Beach Hotel, Hollywood; President McIver in the Chair.

Dr. McIver: "The Second General Session will now come to order.

"One of the most pleasant duties of your president is that of selecting our guest speaker. We believed that this man should have a wide experience in the general field of medicine and of surgery. It is a distinct privilege to present at this time a great physician who is also a great surgeon — Dr. Frank Lahey of Boston."

When Dr. Lahey stepped to the rostrum, the assembly rose in a body and applauded.

Address: "Surgical Lesions of the Stomach, Duodenum and Jejunum and Their Management," by Dr. Lahey.

Dr. McIver thanked Dr. Lahey for his outstanding address.

There being no further business, the second general session adjourned at 12:30 p.m.

HOUSE OF DELEGATES

First House of Delegates

The House of Delegates convened at 9:50 a.m., Tuesday, April 28, 1953 in the Mardi Gras Room of the Hollywood Beach Hotel, Hollywood, Florida, with Dr. Robert B. McIver, President, in the Chair.

Dr. Louis M. Orr, II, Chairman of the Credentials Committee, called the roll and announced that 117 delegates had presented their credentials.

The Chair declared a quorum to be present.

Dr. David R. Murphey, Jr., moved that the delegates be seated.

Seconded by Dr. Chas. W. Bartlett.

Motion carried.

Delegates

ALACHUA—J. Maxey Dell, Jr., James M. McClamroch
BAY—William C. Roberts
BREVARD—Thomas C. Kenaston
BROWARD—Russell B. Carson, Burns A. Dobbins, Jr., Richard A. Mills, Leigh F. Robinson
COLUMBIA—Thomas H. Bates
DADE—James L. Anderson, Edward R. Annis, Herman Boughton, John E. Burch, Jack Q. Cleveland, Maurice P. Cooper, Edward W. Cullipher, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Raymond L. Evans, Ralph W. Jack, Walter C. Jones, Christian Keedy, John D. Milton, Frazier J. Payton, Homer L. Pearson, Jr., Edwin P. Preston, Warren W. Quillian, Hunter B. Rogers, Walter W. Sackett, Jr., Wiley M. Sams, Ralph S. Sappenfield, Donald W. Smith, John W. Snyder, Joseph S. Stewart, Arthur H. Weiland, Leonard L. Weil, *(Absent—Benjamin G. Oren)*
DeSOTO-HARDEE-HIGHLANDS-GLADES—Hubert W. Coleman
DUVAL—Frederick H. Bowen, Edward Canipelli, Hugh A. Carithers, Turner Z. Cason, Frank L. Fort, A. Judson Graves, Karl B. Hanson, Floyd K. Hurt, Edward Jelks, F. Gordon King, John F. Lovejoy, Joseph J. Lowenthal
ESCAMBIA—Herbert L. Bryans, George W. Morse, Walter C. Payne, Alvin L. Stebbins
FRANKLIN-GULF—Albert L. Ward
HILLSBOROUGH—Chas. W. Bartlett, C. Frank Chunn, Herschel G. Cole, H. Phillip Hampton, Linus W. Hewit, Samuel G. Hibbs, Eugene B. Maxwell, David R. Murphey, Jr., *(Absent—Leffie M. Carlton, Jr.)*
INDIAN RIVER—James C. Robertson
JACKSON-CALHOUN—Courtland D. Whitaker
LAKE—C. McK. Tyre
LEE-CHARLOTTE-COLLIER-HENDRY — William H. Grace
LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON—Taylor W. Griffin, Francis T. Holland, Charles F. James, Jr.
MADISON—*(Absent—Eugene D. Thorpe)*
MANATEE—Millard P. Quillian
MARION—Henry L. Harrell
MONROE—Ralph Herz
NASSAU—Benjamin F. Dickens
ORANGE—Eldridge W. Johnson, Lawrence H. Kingsbury, Duncan T. McEwan, Louis M. Orr, II, Frank J. Pyle, Don C. Robertson, Adelbert F. Schirmer
PALM BEACH—Thomas E. Daly, V. Marklin Johnson, Graham W. King, Jr., Ralph M. Overstreet, Jr., Cecil M. Peek, James R. Sory
PASCO - HERNANDO - CITRUS — *(Absent — Karl T. Humes)*
PINELLAS—M. Eldridge Black, Raymond H. Center, Everett M. Harrison, Norval M. Marr, Alvin L. Mills, Richard H. Sinden, Walter H. Winchester, Rowland E. Wood,*(Absent—N. Worth Gable)*
POLK—Jere W. Annis, Ivan W. Gessler, Marion W. Hester, S. L. Watson
PUTNAM—(*Absent—Lawrence G. Hebel)*
ST. JOHNS—A. Clark Walkup
ST. LUCIE-OKEECHOBEE-MARTIN—Richard F. Sinnott
SARASOTA—John M. Butcher, Hugh G. Reaves
SEMINOLE—Orville L. Barks
SUWANNEE—John N. Sims, Sr.
TAYLOR—Mark E. Adams
VOLUSIA—C. Robert DeArmas, Achille A. Monaco, Joseph H. Rutter, Morris B. Seltzer
WALTON-OKALOOSA—William D. Cawthon
WASHINGTON-HOLMES—*(Absent—Frederick B. Jones)*
STATE OFFICERS—Robert B. McIver, Frederick K. Herpel, Francis H. Langley, Erasmus B. Hardee, Samuel M. Day, Shaler Richardson, *(Absent—H. Quillian Jones)*

On motion by Dr. Herbert L. Bryans, seconded by Dr. A. Judson Graves, the minutes as published in the June 1952 Journal were approved.

Dr. McIver: "I will now ask the first vice president, Dr. Francis H. Langley, to take the Chair."

Dr. McIver delivered his presidential address. (The complete address may be found in this Journal on page 887.)

At the close of the address, the membership stood in unison and gave extended applause.

Dr. Langley congratulated the president on his inspiring address.

Dr. McIver resumed the Chair.

Dr. McIver: "You have read in the Handbook, the reason we now have only two delegates to the A.M.A. House of Delegates instead of three, as we anticipated. While we have nearly 2,500 members of our Association, our paid up membership in the A.M.A. was under 2,000, by A.M.A. count on December 31, 1952. We just missed it a little bit, but we missed it. We have only two delegates. At this time, we are to elect one delegate and one alternate to the A.M.A. House of Delegates for two-year terms, beginning January 1, 1954."

Dr. Jelks: "President McIver, Members of the House of Delegates, I am very glad to have the opportunity to make a nomination for our delegate, and I am going to renominate the man whose term now expires. The reasons for it are two: If

you will pardon a personal reference, I know from experience that it takes four to six years for a delegate to the A.M.A. to get known by the other delegates and to attain a position of influence in that body. That is true in all legislative bodies. In our organization, we don't let our presidents serve for long periods of time, but when it comes to the matter of representation, the situation is altogether different.

"Dr. Orr has now been in the House of Delegates a sufficient time to feel perfectly at home and not only to serve you but also to serve the cause of medicine in general. Dr. Orr has not only attended the sessions of that body, but he has brought back to various committees — I know personally of that — and to the Board of Governors, information which has been very valuable in determining the policies of this organization.

"It is a pleasure for me to nominate Dr. Louis M. Orr, II, for delegate to the A.M.A."

Dr. Milton: "I move that the nominations be closed."

Seconded by Dr. Walter C. Jones.

Motion carried.

Dr. McIver: "I will ask the secretary to cast the ballot for Dr. Orr."

Dr. Orr: "I am very happy to be reelected to the House of Delegates of the A.M.A. and I can assure you that I will try to do everything possible for the cause of medicine. At the present moment, I happen to be chairman of the Special Committee on Federal Medical Services of the A.M.A. Also, I have been placed on the Liaison Committee on the all-important subject of non-service connected disabilities."

The Chair called for nominations for alternate delegate to the A.M.A.

Dr. David R. Murphey: "I nominate Dr. Joshua C. Dickinson of Tampa."

Dr. Alvin L. Stebbins moved that nominations be closed.

Seconded by Dr. Herbert L. Bryans.

Motion carried.

Dr. McIver: "The secretary will cast the ballot for Dr. Dickinson."

Dr. McIver recognized Dr. H. Phillip Hampton, Chairman of the Committee on Legislation and Public Policy who spoke briefly.

The Secretary read a telegram from Dr. Herbert E. White, as follows: "I wish for you a most successful 79th meeting. Sorry I can't be with you, the first I have missed in 22 years."

Dr. McIver: "To take the place of Dr. Herbert E. White on the Reference Committee on Health and Education, I would like to appoint Dr. James R. Sory. The three reference committees are as follows:

1. HEALTH AND EDUCATION
   Northeast Dining Room
   David R. Murphey, Jr., *Chairman*
   John D. Milton
   Erasmus B. Hardee
   James R. Sory
   Jere W. Annis

2. PUBLIC POLICY
   Southwest Porch
   Donald W. Smith, *Chairman*
   Edward Jelks
   Duncan T. McEwan
   Francis T. Holland
   N. Worth Gable

3. FINANCE AND ADMINISTRATION
   Men's Card Room
   Frederick K. Herpel, *Chairman*
   Samuel M. Day
   Leigh F. Robinson
   Walter C. Payne
   Warren W. Quillian

The Chair announced that resolutions from the floor would be heard at this time.

Dr. Ralph W. Jack presented a resolution from the Dade County Medical Association on subscriptions to "Today's Health." This was referred to Reference Committee No. 2, Public Policy.

Dr. J. Maxey Dell, Jr., presented a resolution by the Alachua County Medical Society regarding a site for the annual meeting in 1954. This was referred to Reference Committee No. 3, Finance and Administration.

Dr. Frank J. Pyle presented a resolution from the Orange County Medical Society regarding the Doctor Draft Law. This was referred to Reference Committee No. 3, Finance and Administration.

Dr. Don C. Robertson of Orlando presented a resolution by the Orange County Medical Society regarding controversial statements relative to the medical profession. This was referred to Reference Committee No. 2, Public Policy.

Dr. Walter W. Sackett, Jr., presented a resolution from the Florida Academy of General Practice regarding controversial statements relative to the medical profession. This was referred to Reference Commitee No. 2, Public Policy.

Dr. Shaler Richardson, chairman, on behalf of a special committee including Drs. Edward Jelks and Webster Merritt, presented the following:

Resolution

For twenty-seven years Stewart Gordon Thompson served the Florida Medical Association as Managing Director. Giving the best years of his life, working full time, night and day, Dr. Thompson made a unique contribution not only to this Association but also to the medical profession on a nationwide basis. Every detail of the operation of the Association and the publication of The Journal was meticulously scrutinized by him. He strove always to carry out those ideas which he deemed best.

He loved the members of this organization and was always willing to help them in their organizational problems. Unobtrusive at all times, he would never allow his personal feelings to influence his duties, but always worked for the good of the Florida Medical Association. His life was dedicated to the medical profession. As a man, he was an example of rectitude, honesty, and what God intended that a man should be.

BE IT THEREFORE RESOLVED, That this House of Delegates in official session convened this 28th day of April 1953, declare its profound gratitude for this unprecedented contribution and make known its deep regret at the irreparable loss which has come with his passing on Thursday, April 23, 1953, and

BE IT FURTHER RESOLVED, That this House of Delegates is of the confirmed opinion that the progress of the Florida Medical Association over more than a quarter century will forever stand as a monument to this truly great man, and

BE IT FURTHER RESOLVED, That a copy of this resolution be incorporated into the proceedings of this session and a copy sent to Mrs. Thompson and to his daughter, Joan.

Dr. Richardson moved the adoption of this resolution:

Following a chorus of seconds, the Chair called for a rising vote.

The House of Delegates rose in a body.

Duval County Medical Society Resolution — Alteration of regulations governing the physical requirements of physicians for entrance into the Armed Services (Handbook) to Reference Committee No. 3.

Escambia County Medical Society Resolution — Evaluation of physical requirements for physicians being called into military service (Handbook) to Reference Committee No. 3.

The following committee reports were referred as published in the Handbook:

(To Reference Committee No. 1)

Scientific Work, James N. Patterson
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Frazier J. Payton
Venereal Disease Control, Melvin M. Simmons
Tuberculosis and Public Health, Ralph S. Sappenfield
Maternal Welfare, E. Frank McCall
Child Health, Luther W. Holloway
Scientific Assembly and Specialty Group Problem, Herbert E. White

(To Reference Committee No. 2)

Conservation of Vision, Ralph N. Greene, Jr.
Legislation and Public Policy, H. Phillip Hampton
Medical Education and Hospitals, Jack Q. Cleveland
Medical Economics, Reuben B. Chrisman, Jr.
State Controlled Medical Institutions, William D. Rogers
Representatives to Industrial Council, Charles R. Burbacher
Grievance, Walter C. Payne*
*Supplemental report presented and referred.

(To Reference Committee No. 3)

Board of Governors, Robert B. McIver
Public Relations, Eugene B. Maxwell
Necrology, Alvin L. Stebbins*
Advisory to Woman's Auxiliary, C. Robert DeArmas
Councilor Districts and Council, Eugene G. Peek, Jr.
Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell
Emergency Medical Service, James V. Freeman
*Supplemental report presented and referred.

There being no further business, the House of Delegates recessed at 11:15 a.m. to reconvene at 10:30 a.m., Wednesday, April 29, 1953.

Second House of Delegates

The House of Delegates reconvened at 10:37 a.m., Wednesday, April 29, in the Mardi Gras Room of the Hollywood Beach Hotel, Hollywood, Florida; President McIver in the Chair.

Dr. Louis M. Orr, II, Chairman of the Credentials Committee, was recognized and reported that 110 delegates had presented credentials.

The Chair announced that a quorum was present.

On motion duly made, seconded and carried, the delegates were seated.

Delegates

ALACHUA—J. Maxey Dell, Jr., James M. McClamroch
BAY—William C. Roberts
BREVARD—Thomas C. Kenaston
BROWARD—Russell B. Carson, Burns A. Dobbins, Jr., Richard A. Mills, Leigh F. Robinson
COLUMBIA—Thomas H. Bates
DADE—Edward R. Annis, Herman Boughton, John E. Burch, Jack Q. Cleveland, Maurice P. Cooper, Edward W. Cullipher, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Raymond L. Evans, Ralph W. Jack, Walter C. Jones, Christian Keedy, John D. Milton, Frazier J. Payton, Homer L. Pearson, Jr., Jean J. Perdue, Edwin P. Preston, Warren W. Quillian, Hunter B. Rogers, Walter W. Sackett, Jr., Ralph S. Sappenfield, Donald W. Smith, John W. Snyder, Joseph S. Stewart, *(Absent—James L. Anderson, Wiley M. Sams, Arthur H. Weiland, Leonard L. Weil)*
DeSOTO-HARDEE-HIGHLANDS-GLADES—Hubert W. Coleman
DUVAL—Frederick H. Bowen, Edward Canipelli, Hugh A. Carithers, Turner Z. Cason, Frank L. Fort, A. Judson Graves, Karl B. Hanson, Floyd K. Hurt, Edward Jelks, F. Gordon King, John F. Lovejoy, Joseph J. Lowenthal
ESCAMBIA—Herbert L. Bryans, George W. Morse, Walter C. Payne, Alvin L. Stebbins
FRANKLIN-GULF—Albert L. Ward
HILLSBOROUGH—C. Frank Chunn, Herschel G. Cole, H. Phillip Hampton, Linus W Hewit, Samuel G. Hibbs, Eugene B. Maxwell, David R. Murphey, Jr. *(Absent—Chas. W. Bartlett, Leffie M. Carlton, Jr.)*
INDIAN RIVER—James C. Robertson
JACKSON-CALHOUN—Courtland D. Whitaker
LAKE—C. McK. Tyre
LEE-CHARLOTTE-COLLIER-HENDRY — William H Grace

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON—Taylor W. Griffin, Francis T. Holland, Charles F. James, Jr.
MADISON—*(Absent—Eugene D. Thorpe)*
MANATEE—Millard P. Quillian
MARION—Henry L. Harrell
MONROE—Ralph Herz
NASSAU—Benjamin F. Dickens
ORANGE—Eldridge W. Johnson, Lawrence H. Kingsbury, Duncan T. McEwan, Louis M. Orr, II, Frank J. Pyle, Don C. Robertson, Adelbert F. Schirmer
PALM BEACH—Thomas E. Daly, V. Marklin Johnson, Graham W. King, Jr., Ralph M. Overstreet, Jr., Cecil M. Peek, James R. Sory
PASCO-HERNANDO-CITRUS—*(Absent — Karl T. Humes)*
PINELLAS—M. Eldridge Black, Raymond H. Center, Everett M. Harrison, Norval M. Marr, Alvin L. Mills, Richard H. Sinden, Walter H. Winchester, Rowland E. Wood, *(Absent—N. Worth Gable)*
POLK—Jere W. Annis, Ivan W. Gessler, Marion W. Hester, S. L. Watson
PUTNAM—*(Absent—Lawrence G. Hebel)*
ST. JOHNS—A. Clark Walkup
ST. LUCIE-OKEECHOBEE-MARTIN—Richard F. Sinnott
SARASOTA—John M. Butcher, Hugh G. Reaves
SEMINOLE—*(Absent—Orville L. Barks)*
SUWANNEE—*(Absent—John N. Sims, Sr.)*
TAYLOR—Mark E. Adams
VOLUSIA—C. Robert DeArmas, Joseph H. Rutter, Morris B. Seltzer, *(Absent—Achille A. Monaco)*
WALTON-OKALOOSA—William D. Cawthon
WASHINGTON-HOLMES—*(Absent—Frederick B. Jones)*
STATE OFFICERS—Robert B. McIver, Frederick K. Herpel, Francis H. Langley, Erasmus B. Hardee, Samuel M. Day, Shaler Richardson, *(Absent—H. Quillian Jones)*

The Chair called for the report of Dr. David R. Murphey, Jr., Chairman of Reference Committee No. 1, Health and Education.

Report of Reference Committee No. 1

Dr. Murphey: "President McIver, Members of the House of Delegates, your Reference Committee No. 1 on Health and Education met as instructed with 100 per cent attendance. The members of this Committee were Drs. John D. Milton, Erasmus B. Hardee, James R. Sory, Jere W. Annis and your chairman.

"The Report of the Committee on Scientific Work is approved as presented and I move its adoption."

Seconded by Dr. Homer L. Pearson, Jr.

Motion carried.

Report of Committee on Scientific Work

James N. Patterson, *Chairman*

The Scientific Work Committee met at the Orange Court Hotel, Orlando, on Sunday, Dec. 14, 1952, to choose the papers to be presented at the Scientific Assemblies of the Florida Medical Association at Hollywood, April 27, 28 and 29. Your Committee believes that the papers selected will result in a well-rounded program of interest to the entire membership. In the program you will have the opportunity of hearing from one eminent speaker from a foreign country, five prominent out-of-state speakers as well as from a large number of our state colleagues.

Last year the Scientific Work Committee presented a symposium on the subject of Hypersplenism with Dr. Steven O. Schwartz, an internationally known hematologist, as moderator and six able Florida physicians who assisted him by presenting the various aspects of the subject. Judging from the excellent attendance at this symposium, most all of whom stayed throughout the entire session, as well as from the many favorable comments heard regarding this experiment, it can be stated, without fear of contradiction, that the symposium was most successful. Due to conflict of dates of our coming meeting with one of an international medical organization, your Committee was unable to present the symposium planned for this year. It is hoped that next year's Committee on Scientific Work will be more fortunate in arranging for a symposium of general interest to our membership.

Respectfully submitted,
James N. Patterson, *Chairman*

Dr. Murphey: "The Report of the Committee on Medical Postgraduate Course as presented by Dr. Turner Z. Cason is approved with the exception of the last paragraph of the report relative to the disbursement of funds. It is the opinion of the Committee that this is contrary to the Constitution and By-Laws of the Association as recorded in the By-Laws, Chapter VII, Sec. 9. The Committee recommends that this section of the report be referred to the Board of Governors for study.

"I move the adoption of this report as amended."

Motion was duly seconded.

The Chair recognized Dr. Turner Z. Cason, Chairman of the Committee on Medical Postgraduate Course.

Dr. Cason: "Unfortunately, I could not attend that committee meeting yesterday afternoon. It was my understanding, when the committee reported last year, and it was also the understanding of Stewart Thompson, that the funds then kept in a special account of the Florida Medical Association should be transferred to the account of the Director of the Department of Medicine of the University of Florida. That was done.

"This account is entirely separate and in no way connected with the Florida Medical Association. I have a dual role, one as Director of the Department of Medicine of the University of Florida, and one as Chairman of the Medical Postgraduate Course Committee, which is advisory to the Director. As Chairman of the Postgraduate Course Committee, I do not allow the Director of the Department of Medicine to do anything without the approval of the committee.

"Stewart Thompson transferred the funds as directed. The account is audited by the auditor of the University of Florida, the books are set up by the University, and it has nothing to do

with the accounts of the Florida Medical Association. This was just put in the report as information to you. We felt you would like to know how much it was and how it was being spent. It had nothing to do with the Florida Medical Association finances or accounts."

Motion carried.

Report of Committee on Medical Postgraduate Course

Turner Z. Cason, *Chairman*

The Twentieth Annual Graduate Short Course for doctors of medicine was held in Jacksonville, June 23-28, 1952, with a total attendance of 131 physicians.

The annual Diabetes Seminar was held in West Palm Beach, March 27-28, 1952, with an attendance of 81.

An Obstetrical and Gynecological Seminar presented by the Faculty of the Department of Medicine was held at Panama City with 13 physicians in attendance.

A Seminar on Diagnosis was the special course offered just prior to the Short Course and was held in Jacksonville, June 19-21, with 55 in attendance.

These courses were outlined and approved by the Medical Postgraduate Course Committee and preparations were made by the Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association and the Florida State Board of Health.

The annual Ophthalmology and Otolaryngology Course was held in Miami on January 12-17, 1952, with 206 physicians attending. Representatives from thirty states, Canada and Cuba were in attendance.

The Sixth Annual Southeastern States Cancer Seminar was held in Tampa, October 30-November 1, 1951, with a total registration of 225. These lectures were approved by the Department of Medicine for credit hours to those physicians in attendance.

The Medical Postgraduate Course Committee met at the George Washington Hotel, Jacksonville, on December 7, 1952. Dr. Turner Z. Cason, Chairman, Dr. Francis T. Holland, Dr. Arthur J. Butt, and Dr. Lorenzo L. Parks were present.

After a welcome to the new members of the Committee, the Chairman outlined the proposed idea of sending questionnaires to all the physicians in the state asking what they most wanted in the way of graduate medical education and suggestions for improved attendance. Following a discussion of this question and the ways other states had attempted to solve the problem of attendance, it was agreed that the Chairman should carry out this idea after consulting with trained individuals in this type of investigation.

The question of deducting expenses to graduate medical courses from income tax returns was reviewed and it was suggested that the Chairman contact the American Medical Association further and also California to ascertain information and developments.

The Committee approved the dates of June 22-28, 1953, for the Twenty-First Annual Graduate Short Course. Suggestions were made and recorded for new teachers in the fields of surgery, pediatrics, gynecology and diseases of the chest. For the Specialized Course prior to the Short Course, the subject of Gastroenterology was approved and the Chairman was advised to outline such a course.

The Diabetes Seminar was discussed and approved as being presented in St. Petersburg in 1953 in cooperation with the State Diabetes Association which has just been organized and approved by the National Diabetes Association.

The Committee approved continuation of the one day graduate courses to be presented upon request by the Faculty of the Department of Medicine.

Respectfully submitted,
Turner Z. Cason, *Chairman*

Dr. Murphey: "The report of the Committee on Cancer Control, Dr. Frazier J. Payton, Chairman, is approved as presented.

"I move it be adopted."

Seconded by Dr. C. Frank Chunn.

Motion carried.

Report of Committee on Cancer Control

Frazier J. Payton, *Chairman*

Because of the necessary limitation of time and space, many factors of interest are necessarily omitted from this report. Your committee wishes first to report that the Florida State Board of Health has spent $160,000 on cancer in 1952, servicing about 1,700 new cases. The American Cancer Society at the same time has spent $110,000 in Florida for Cancer Control and in addition has sent $44,000 to the National organization for use in cancer research.

The Southeastern States Cancer Seminar held in Tampa in 1952 had a total registration of only 225 at a total cost of $2,800.00. During the same year, the Crossroads Cancer Seminars had a total registration of 230 doctors at a total cost of $600.00 for the year. Because of the relatively high cost, and declining attendance of the Cancer Seminars, the Florida Cancer Council voted to recommend discontinuance of the Seminar for one year, and to concentrate on other means of professional education. The Crossroads Cancer Seminars, having shown better results at lower cost, it has been recommended that they be improved and enlarged. In addition, it is the recommendation of your Committee that all county medical societies in the state be urged to have at least one program on cancer during 1953. The American Cancer Society and Florida State Board of Health in certain instances, were considering defraying the expenses of speakers for these meetings.

Steps have been taken to urge all tumor clinics in the state of Florida to conform to the requirements set by the Cancer Committee of the American College of Surgeons. The clinics in the state of Florida must operate with the full approval of the local medical society, which approval must be renewed annually.

A pamphlet, "Cancer Examination," has been approved by the Board of Governors of the Florida Medical Association and the Florida Cancer Council. It has been published in bulk at the expense of the American Cancer Society, Florida Division, and will be mailed to every physician in the state. It will serve as a guide to physicians to crystallize in their minds, what a so-called cancer examination should consist of, and also will encourage the public to request such examination and to acquaint them with what they may expect of their physicians. This pamphlet is patterned after a similar pamphlet which has been used successfully in Wisconsin for several years.

The Florida Cancer Council, during 1952, approved the establishment of two new tumor clinics in Florida, one at St. Vincent's Hospital in Jacksonville, and the other in Sarasota.

Your Chairman wishes to commend the members of his Committee, who, although they have not been called upon for specific duties, have worked earnestly in support of the Cancer Control program in their districts. Without this wholehearted support and the example set, the Florida State Cancer Control program would not have progressed as it has.

Respectfully submitted,
Frazier J. Payton, *Chairman*

Dr. Murphey: "The report of the Committee on Venereal Disease Control, Dr. Melvin M. Simmons, Chairman, is approved as presented.

"I move its adoption."

Seconded by Dr. Frederick K. Herpel.

Motion carried.

Report of Committee on Venereal Disease Control

Melvin M. Simmons, *Chairman*

The field of venereal disease offers one of the greatest opportunities to the medical profession for complete mastery of several of the oldest enemies of man. With the advent of penicillin and other antibiotics, therapy has become both easy and economical. Thus we are confronted primarily with the problem of finding cases.

Statistically, there has been no decrease in the reported incidence of syphilis this year. However, there is an increase in the latent cases as contrasted to a decrease in the primary and secondary cases being discovered. This could be interpreted as a trend toward decrease incidence which would be reflected in the reporting of future years. Cases reported have been almost equally divided between private physicians and the clinics of the Florida State Board of Health.

With diagnosis and treatment now reduced to relatively easy and economical procedures, the primary effort can now be expended in the direction of finding cases. Mass surveys and compulsory examination methods have been proved to be less effective than contact follow-up and education by experienced personnel.

The busy physician obviously cannot spare his own time for contact searches. Therefore, this is the field which offers most fruitful results by cooperation with our established State Board of Health.

State Board of Health personnel are trained in follow-up work and are at the disposal of all physicians in the state. Your Committee therefore recommends:

1. That each physician of the state be encouraged to take advantage of contact follow-up as offered, as the basic step in venereal disease control.
2. County medical societies continue educational programs to stimulate interest in this problem both in the medical profession and the public.

Respectfully submitted,
Melvin M. Simmons, *Chairman*

Dr. Murphey: "The report of the Committee on Tuberculosis and Public Health, Dr. Ralph S. Sappenfield, Chairman, is approved with the following amendment: We recommend that the committee further study the abuse and use of narcotics and barbiturates and make specific recommendations.

"I move the adoption of this report as amended."

Seconded by Dr. Ralph Herz.

Motion carried.

Report of Committee on Tuberculosis and Public Health

Ralph S. Sappenfield, *Chairman*

Your Committee on Tuberculosis and Public Health has had no scheduled meeting this year. The activities needing attention were handled by correspondence.

Your Chairman and members of the Committee have attempted to function with the Florida Tuberculosis and Public Health Association. The Southern Tuberculosis Conference was held in Miami Sept. 11-12, 1952. After a review of this Conference and the work of the Florida Tuberculosis Association, your Committee feels that we should first, encourage attendance at the Tuberculosis Conferences; second, point out the need of increasing the interest of the doctors in the tuberculosis control programs; and third, encourage guidance for the local committee of the Tuberculosis Association.

It is the belief of the Committee that many of the duties which should be performed by this Committee have been assumed by other societies, since the state society has failed to carry its load.

The Committee has not been called upon this year in regard to the Diabetes Control Project. Before the Diabetes Detection Week, services of this Committee were offered at a state level and at a county level. The Committee looks with favor upon such programs but finds it difficult to participate.

Programs of other states were requested in order that their experiences might be reviewed. These were long range programs and contained many points of our allied societies.

It has also been brought to the Committee's attention that a program is necessary and should be instituted concerning the abuse and use of narcotics and barbiturates; and it is the feeling that a committee should work closely with and upon the advice of the Bureau. Many members of our profession need assistance.

Respectfully submitted,
Ralph S. Sappenfield, *Chairman*

Amendment

The Reference Committee recommends that the committee further study the abuse and use of narcotics and barbiturates and make specific recommendations.

Dr. Murphey: "The report of the Committee on Maternal Welfare, Dr. E. Frank McCall, Chairman, is approved with commendation.

"I move it be adopted."

Seconded by Dr. Homer L. Pearson, Jr.

Motion carried.

Report of Committee on Maternal Welfare

E. Frank McCall, *Chairman*

We have formed no new Maternal Welfare Committees in the state this year, but those already active are doing an excellent job of reducing the maternal deaths within their counties, and their continued comments and criticisms are helping a great deal in the prevention of maternal deaths.

The Maternal Welfare Committee sponsored by the State Boards of Health of Georgia, Florida, and South Carolina, held an Obstetric and Pediatric Seminar at Daytona Beach September 8, 9, and 10, 1952. This meeting was better attended than the previous year — total registration being 229 with a Florida registration of 187. The faculty for this meeting was as follows:

Dr. R. Gordon Douglas, New York Hospital; Dr. F. Bayard Carter, Duke University; Dr. Carl Parker Huber, Indiana University; Dr. Fred L. Adair, Maitland, Fla.; Dr. William J. Dieckmann, University of Chicago; Dr. Clement A. Smith, Harvard University; Dr. Edith L. Potter, University of Chicago; Dr. John Adriani, Louisiana State University; Dr. James C. Lanier, Jacksonville, Fla.

For this meeting we were able to obtain six exhibitors which helped in a small way to defray the cost of the meeting. The rest was provided by the Florida State Board of Health (Bureau of Maternal and Child Health). This Committee Chairman subsidized the meeting with $480.

A canvas of the state reveals that most of the doctors would like to have this meeting continued, and Georgia and South Carolina have signified their willingness to cooperate. We hope to incorporate in this year's meeting Alabama and Mississippi, as they have both indicated their desire to join this group.

Plans are in progress to secure twenty or twenty-five exhibitors, and if this is possible, this meeting will from now on be self-supporting.

It is with a great deal of pleasure that we report only sixty-one maternal deaths in Florida last year — twenty-six white and thirty-five Negro. This is an overall reduction of thirty-three per cent, and gives us a maternal mortality of 0.8 per 1,000, which is the lowest in the history of Florida and will rank very well among the top states in the nation. Credit, of course, can go to the use of

blood and antibiotics, but the greatest credit must go to the doctor himself who has shown his willingness and desire to do better obstetrics.

Respectfully submitted,
E. Frank McCall, *Chairman*

Dr. Murphey: "The report of the Committee on Child Health, Dr. Luther W. Holloway, Chairman, is approved with the following amendment: It is recommended that the resolution offered by the committee relative to the State School Lunch Program be approved with the following addition to the last paragraph of the resolution, namely, the addition of 'the principle of.' This paragraph to now read, 'Therefore be it resolved that the Florida Medical Association in annual session go on record as approving the principle of a State School Lunch appropriation.'

"I move that this be approved as amended."

Seconded by Dr. John D. Milton.

Motion carried.

Report of Committee on Child Health

Luther W. Holloway, *Chairman*

Resolution

WHEREAS, A survey originated by the Department of Education of the State of Florida endorses the need for a State School Lunch appropriation, and

WHEREAS, There will be presented at the current session of the Legislature a Bill — creating a School Lunch Fund to be provided from the State General Fund; and prescribing the powers and duties of County Boards of Public Instruction and the State Board of Education relating to the operation of school lunch programs in each of the counties; and prescribing the procedure for disbursing Florida School Lunch Act Funds,

THEREFORE BE IT RESOLVED, That the Florida Medical Association in annual session go on record as approving the principle of a State School Lunch appropriation.

Respectfully submitted,
Luther W. Holloway, *Chairman*

Dr. Murphey: "The report of the Special Committee on Scientific Assembly and Specialty Group Problem, Dr. Herbert E. White, Chairman, is approved.

"I move that it be adopted."

Motion duly seconded and carried.

Report of Special Committee on Scientific Assembly and Specialty Group Problem

Herbert E. White, *Chairman*

Your Committee on Scientific Assembly and Specialty Group Problem recommends that no change be made in the procedure which was put into effect as outlined in detail in the Board of Governors Annual Report to the House of Delegates in 1949, and reproduced on page 779 of the June 1949 Journal.

For the past three years, the Scientific Work Committee has been authorized to invite the specialty groups to submit applications for papers for presentation at the scientific assemblies.

The Scientific Work Committee was empowered to accept papers from any out-of-state speakers who are invited by any of the specialty groups or by the Scientific Work Committee to be present at the scientific assemblies.

A number of essayists from out-of-state who presented excellent papers at specialty group meetings the day before the Association's annual meeting (Sunday), appeared at one of the scientific assemblies during the following days. These essayists presented valuable papers of general interest.

Many worth-while papers could not be included in the scientific assembly program because the Chairman of the Association's Scientific Program Committee was not contacted soon enough. It is very important that the specialty group officers notify the Chairman of the Association's Scientific Work Committee not later than November of the previous year, the name of the guest essayist and the title of his paper. In a number of instances, the specialty group officers have requested a guest speaker to be placed on the scientific assembly program late in December or in January. By this time, the scientific assembly programs have all been completed and are ready for publication in the Convention number of The Journal. If the specialty groups will start earlier to select their out-of-state essayists, it will coordinate the plan now in effect and be the means of having many more excellent essayists on the scientific assembly programs.

The members of your Committee are convinced that if the present plan is understood, much better results will be obtained.

The consensus of the members of your Committee is that establishing sections is not advisable. If two or more scientific sections were in session simultaneously, there would be more dissatisfaction than is now being experienced by having specialty group programs going on simultaneously.

At 11:00 a.m. on Sunday, December 14, 1952 in Orlando, a meeting was held to consider the entire problem. The Chairman of this Committee mailed a personal letter to the presidents and secretaries of all county medical societies, as well as to the presidents and secretaries of specialty groups. On November 11, 1952, "Briefs" news letter was mailed to every member of the Association urging that anyone interested in this problem should attend the meeting in Orlando in December. Copy of the resolution was reproduced in this issue of "Briefs."

This open forum was well attended and the general discussion was of particular interest. Representatives from county medical societies as well as representatives from specialty groups appeared and were given an opportunity to express the wishes of the members they represented.

Following the open forum, the Committee convened and discussed the problem confronting it, the results of which appear in the foregoing.

The members of this Special Committee on Scientific Assembly and Specialty Group Problem are Drs. Herbert E. White, Chairman, Jere W. Annis, Reuben B. Chrisman, Jr., Frederick K. Herpel, Louis M. Orr, II, R. Wynn S. Owen, James N. Patterson, Shaler Richardson and William C. Roberts.

Respectfully submitted,
Herbert E. White, *Chairman*

Report of Reference Committee No. 2

The Chair called upon Dr. Donald W. Smith, Chairman, Reference Committee No. 2, Public Policy.

Dr. Smith: "Reference Committee No. 2 met as instructed with Drs. Edward Jelks, Duncan T. McEwan, Francis T. Holland and the chairman in attendance.

"The resolution presented by the Dade County Medical Association on subscriptions to 'Today's Health' is approved. One comment should be made. It was pointed out that the $1.50 of the annual A.M.A. dues of each dues-paying member of the A.M.A. to be transferred over to the 'To-

day's Health' magazine for a subscription to his office, is nothing more than a continuing subsidy of this magazine, which would put a copy in every physician's office, and would result in increased circulation of this publication.

"I move its adoption."

Seconded by Dr. John D. Milton.

Motion carried.

Resolution

WHEREAS, we are highly conscious of the potency of the physician's office as an integral part of sound medical public relations, and

WHEREAS, we are of the belief that the American Medical Association's publication, "Today's Health," is designed to serve the interests of the lay public from the standpoint of good health information, and

WHEREAS, we feel more physicians' offices should have a copy of "Today's Health" available to the physicians' patients,

NOW, THEREFORE BE IT RESOLVED, That Dade County Medical Association, in official meeting convened, goes on record as petitioning the Florida Medical Association to direct to the American Medical Association a resolution calling for the setting aside of One Dollar and Fifty Cents ($1.50) of the annual dues of each of the dues paying members of American Medical Association for the purpose of purchasing a subscription to "Today's Health" for each of the dues paying members, said subscription to be addressed to the office of each of the physicians.

Done on this 7th day of April, 1953.

Dr. Smith: "The two resolutions of the Orange County Medical Society and the Florida Academy of General Practice, after considerable discussion, have been combined into one resolution by your Reference Committee. This substitute resolution is approved, and it is recommended that it be sent to the Board of Governors for study.

"I move the adoption of this substitute resolution."

Seconded by Dr. Ralph Herz.

Motion carried.

Resolution

The Reference Committee recommends that the two resolutions presented by the Orange County Medical Society and the Florida Academy of General Practice, which were later combined as a joint Resolution, be substituted by a Directive to the Board of Governors of the Florida Medical Association to investigate and study the matters contained therein; and further, that the Board of Governors direct our Delegates to the American Medical Association to present this matter to that Association in accordance with the results of their findings, in the form of an appropriate Resolution.

Dr. Smith: "There was no report from the Committee on Conservation of Vision.

"The report of the Committee on Legislation and Public Policy, Dr. H. Phillip Hampton, Chairman, is approved with deep appreciation for the excellent work of this committee.

"I move its adoption."

Seconded by Dr. Alvin L. Stebbins.

Motion carried.

Report of Committee on Legislation and Public Policy

H. Phillip Hampton, *Chairman*

The primary activities of your Committee have been the planning and preparation for the 1953 Session of the Florida State Legislature.

Your Committee studied all the proposed legislation received from the County Medical Societies, referred by the Association's President, and requested by the House of Delegates.

This proposed legislation was presented with recommendations to the Pre-Legislative Joint Meeting of the FMA-Board of Governors, Members of the House of Delegates, Bureau of Public Relations and Committee on Legislation and Public Policy held on January 18, 1953 in Tampa. The proposed legislation was discussed at this meeting and a definite program was adopted.

The more important proposed bills were sent to the chairman of the Legislative Committee, and a copy to the President, of each County Medical Society urging them to inform the County Medical Society and also explain them to the Senator and Representatives of their county, prior to the 1953 Session of the Legislature.

An office will be maintained at Tallahassee during April and May as was done at the last session of the Legislature. This office is for the convenience of the legislators and others who may seek information on problems concerning medicine, health and education as they effect legislation for the protection of Florida citizens.

A copy of "Today's Health" is again being sent to Florida's United States Senators, Representatives, the Governor, his Cabinet, and to each State Senator and Representative. Letters have been received from many of them expressing their appreciation.

Your chairman and other members of the Association and Woman's Auxiliary attended the AMA Regional Conference on Legislation held in Jacksonville on October 15, 1952. A Review of Health Legislation introduced in the 82nd Congress and that likely to be introduced in the 83rd Congress was presented. Dr. Frank E. Wilson, Director of the AMA's Washington Office presided. Your Committee has cooperated with the Washington Office in every way possible.

On behalf of the Committee, I desire to express appreciation for the assistance rendered by the President, Secretary, Supervisor of the Association's Bureau of Public Relations, and other State Association officers; to the members of the Legislative Committees of the County Medical Societies, and to the many individual members who have responded when called on for assistance.

Respectfully submitted,
H. Phillip Hampton, *Chairman*

Dr. Smith: "The report of the Committee on Medical Education and Hospitals, Dr. Jack Q. Cleveland, Chairman, is approved with the following amendment: That the Board of Governors investigate, study and make recommendations as to how we could increase our contributions from the state of Florida to the American Medical Education Foundation.

"I move its adoption as amended."

Seconded by Dr. Erasmus B. Hardee.

Motion carried.

Report of Committee on Medical Education and Hospitals

Jack Q. Cleveland, *Chairman*

Since the Committee's special assignment for 1952 was to urge gifts to the American Medical Education Founda-

tion, your Chairman used all his efforts toward that special assignment. A meeting of the full Committee was not held, but a conference was held with Dr. Julius C. Davis, the previous year's Chairman, and his advice was sought and utilized.

Your Chairman attended two meetings in Chicago of the forty-eight Chairmen of State Medical Education and Hospital Committees. The first of these meetings was held in February 1952 and the second one in January 1953. Both these meetings were called by the Officers and Board of Directors of the American Medical Education Foundation.

The overall national response in 1952 was better than in 1951, but more individual contributors are needed to accomplish the Foundation's purpose. This purpose, as we see it, is to stabilize American Medical Schools and permit them to continue operations at present and ever-expanding levels.

In 1952 the doctors of the Florida Medical Association contributed $3,160 to the Foundation. It should be pointed out, again, that contributions to the Foundation can be designated to be sent to the donor's Alma Mater.

Undoubtedly, the greatest problem facing all our medical schools, at present, is the difficulty of obtaining and holding faculties because of lack of adequate funds for salaries.

All of us in the Florida Medical Association, as products of our existing system of medical education, should recognize our responsibilities to the American medical profession, to American medical education and to our Alma Maters.

The goal for 1953 is two million dollars for the Foundation. Not a penny of funds contributed is used to defray the administrative expenses of the Foundation and the same holds true of the National Fund for Medical Education which is the lay counterpart of the A.M.E.F.

Both organizations are underwritten by their sponsors for all expenses co-incident with raising money for medical education.

Last year, the Georgia Medical Association gave $10,000 to the Foundation. This gift from a neighboring state association should give our Association food for thought as to our responsibilities.

Amendment

The Reference Committee recommends that the Board of Governors investigate, study and make recommendations as to how we could increase our contributions from the state of Florida to the American Medical Education Foundation.

Respectfully submitted,
Jack Q. Cleveland, *Chairman*

Dr. Smith: "The report of the Committee on Medical Economics, Dr. Reuben B. Chrisman, Jr., Chairman, is approved.

"I move the report be adopted:"

Motion duly seconded and carried.

Report of Committee on Medical Economics

Reuben B. Chrisman, Jr., *Chairman*

Your Committee has become aware of the fine work done in previous years by the Fee Schedule Sub-Committee under the direction of Dr. John D. Milton and the accomplishments of last year's Medical Economics Committee, whose Chairman was Dr. Merritt R. Clements.

The medical retirement plan, now under consideration, is a reflection of vision and hard work on the part of the Board of Governors.

Your Committee, during the year, queried officials of medical societies in 47 states and 4 territorial possessions, requesting information on activities of their Economics Committees. A majority of these replied and many sent valuable information. The Committee is making an analysis and study of pertinent data obtained with a view to making recommendations as a guide for the Medical Economics Committee during the coming year.

Under consideration, at present, is a plan for preparing a leaflet, "How to Avoid a Malpractice Suit," containing valuable medico-legal information. The Committee will recommend free distribution of the pamphlet to every member of the Florida Medical Association.

Other projects under study include a plan for making available the A.M.A. plaque "To All My Patients" in each physician's office, and further efforts for promoting voluntary Health Insurance. These and other suggestions gained from the nation-wide survey will be placed in the hands of the new Committee.

Your Committee recommends that individual physicians, county societies and the State Association actively urge the passage of HR-10 and HR-11 (identical bills), which propose tax postponement for self-employed to create retirement annuities. The A.M.A. is supporting this legislation and suggests that all physicians indicate to their Congressmen their interest in and approval of the proposed bills.

Respectfully submitted,
Reuben B. Chrisman, Jr., *Chairman*

Dr. Smith: "The report of the Committee on State Controlled Medical Institutions, Dr. William D. Rogers, Chairman, is approved with commendations.

"I move the report be adopted."

Seconded by Dr. Ralph Herz.

Motion carried.

Report of Committee on State Controlled Medical Institutions

William D. Rogers, *Chairman*

As Chairman of the Committee on State Controlled Medical Institutions, I take pleasure in submitting the following report on the Florida Farm Colony at Gainesville, the Florida State Hospital at Chattahoochee, and the Florida State Hospital at Arcadia, the hospital at Arcadia being a branch of the main hospital at Chattahoochee.

The patient population at the Florida Farm Colony has remained constant during the last year, with some steady increase in the number awaiting admission to that institution.

However, during the past year nine additional ward buildings have been constructed and these are virtually complete. Five of these are for white patients, and four of them are forming the first part of a Negro unit to be established in that institution. These buildings will accommodate roughly 180 white and 150 Negro patients. The building program also has provided two new wings on the hospital building, which will provide the necessary hospital facilities for the Negro units. There has also been an addition to the clinic building to house necessary medical and dental clinical facilities for the Negro population.

Also during the past year a clinical psychologist and a social worker have been added to the staff of this institution.

It is the belief of the writer that conditions in this institution have continued to improve during the past year in housing, as well as in treatment and the program for rehabilitation.

The Florida State Hospital at Chattahoochee at present has 6,352 patients and is accepting patients only on a replacement basis. However, between 1,500 and 1,600 patients are being received each year. Usually the gain in permanent population averages around 250 each year due to the many chronic type cases now being received.

The increase in the number of applications for elderly patients is becoming quite marked, as now roughly 40 per cent of all applications received are for people suffering from senility or arteriosclerosis.

At the present time two buildings of 350 beds each are being constructed for Negro patients, one to house

men and one to house women. This will relieve the crowded conditions somewhat in the Negro departments.

Within the last few weeks a new receiving hospital for white women has just been completed, which has a bed capacity of 150. This will add to the present treatment and receiving facilities and render them quite adequate.

Additional space for the housing of elderly patients is urgently needed, as well as a hospital for tuberculous patients. At the present time there are 320 cases of active and arrested tuberculosis which are under observation in the institution.

During the last year treatment facilities have been expanded, with marked expansion in the occupational therapy and recreational departments.

The institution at Arcadia houses 940 patients, and during this year construction was started to furnish 250 additional beds for white men patients, and 50 beds for white women patients. These buildings will be completed within the near future.

In view of the marked increase in population of the State of Florida, as well as considering the locations of the institutions and their size, it is believed that there is urgent need for additional facilities on the lower East Coast for the care and treatment of the mentally ill. These should be constructed of sufficient size in the beginning to help take the load off the institution at Chattahoochee, especially as it has now definitely grown into a larger institution than it should be.

Respectfully submitted,
William D. Rogers, *Chairman*

Dr. Smith: "The report of the Committee on Representatives to Industrial Council presented by Dr. Charles R. Burbacher, Chairman, is approved with the following amendment: That the report be revised after the first sentence in paragraph 2 to read: Dr. John H. Mitchell submitted suggestions by which the relationship between industries and the profession might improve the protection and care of employees.

"I move this report be adopted as amended."

Seconded by Dr. Samuel G. Hibbs.

Motion carried.

Report of Representatives to Industrial Council

Charles R. Burbacher, *Chairman*

The Committee on Representatives to Industrial Council transacted the usual amount of routine business, principally in the form of answering communications to various allied organizations, both state and national.

Dr. John H. Mitchell of Jacksonville represented Florida at the Thirteenth Annual Congress on Industrial Health sponsored by the Council on Industrial Health of the American Medical Association. Dr. John H. Mitchell submitted suggestions by which the relationship between industries and the profession might improve the protection and care of employees.

Respectfully submitted,
Charles R. Burbacher, *Chairman*

Dr. Smith: "The report of the Committee on Grievance presented by Dr. Walter C. Payne, Chairman, is approved with the following supplemental report amended to read: That, where possible, the Grievance Committees of the County Societies be composed of the five last living presidents of the society, as is done on the state level.

"I move the report be adopted as amended."

Seconded by Dr. Alvin L. Mills.

Motion carried.

Report of Grievance Committee

Walter C. Payne, *Chairman*

There are days when your Chairman feels discouraged. However, I am happy to report that such days are gradually occurring less frequently. There is no doubt that we are making progress, even though we have a long way to go before we reach our maximum efficiency.

I have been reviewing the past year's work in an effort to determine what should be done to improve our service. The conclusion is easily reached. That which is most needed is that the members of our Association should be better informed as to the aims and objects of the Grievance Committee. It is evident that too many of our County Mediation Committees do not understand what is expected of them. I feel that it is the duty of our State Committee to inform them properly, and that will be one of the main objectives of this Committee during the coming year.

It seems that it is in order to name a few of the problems that are giving us most concern at this time:

Firstly;

When a complaint is referred to the County Mediation Committee, it should receive prompt consideration. Nothing impresses a complainant more than prompt investigation. On the other hand, he becomes understandably impatient and critical of long delays. If the delay is too prolonged, much potential good public relations is sacrificed, no matter how well the investigation is finally conducted. Your Chairman often has to make repeated requests before a complaint is considered.

Secondly;

We would like to emphasize the importance of a personal interview where this is possible. In those cases where such an interview is not possible because the complainant resides elsewhere, a courteous correspondence is urged. When an investigation has been conducted properly, the complainant should feel satisfied that he has had fair and courteous treatment. He should be left with a feeling of respect for the Committee, even though he may be disappointed at the result. Nothing could be more disastrous to our public relations than that the complainant should feel that the investigation was prejudiced and in effect was a "whitewash" for the doctor involved.

Thirdly;

When an investigation of a grievance has been completed, the complainant, the one complained against, and the State Grievance Committee should be informed of the result. The reaction of the complainant to the findings of the Mediation Committee should also be recorded and the State Committee informed. No case is complete until our State Committee has this information. It is with this knowledge that we are able to determine whether our efforts in a particular case have been successful or unsuccessful; whether the effect on our public relations has been helpful or harmful. We should bear in mind in each investigation that we are handling a two edged sword, and that if the investigation is bungled it were better that no investigation had been done.

Our Committee wishes to acknowledge the courtesies shown it by the various Mediation Committees during the year. It pledges its best efforts to be more helpful to the Mediation Committees during the coming year. As more experience is gained, your State Committee is better prepared to increase its usefulness.

Supplement

It is strongly urged that, where possible, the Grievance Committees of the County Societies be composed of the five last living presidents of the society, as is done on the state level.

Respectfully submitted,
Walter C. Payne, *Chairman*

Report of Reference Committee No. 3

Dr. Frederick K. Herpel, Chairman of Reference Committee No. 3, Finance and Administration, was recognized and asked to present the report of that committee, which was composed of Drs. Samuel M. Day, Leigh F. Robinson, Walter C. Payne, Warren W. Quillian and the chairman.

Dr. Herpel: "The resolution presented by the Orange County Medical Society on the Doctor Draft Law is recommended for approval.

"I move its adoption."

Seconded by Dr. Hugh G. Reaves.

Motion carried.

Resolution

WHEREAS, the Doctor Draft Law (Public Law No. 779) expires 30 June, 1953, and

WHEREAS, the Congress of the United States is in the process of deliberating and eventually enacting a new law for the equitable drafting of physicians, dentists, veterinarians and allied specialists into the military services, and

WHEREAS, the physicians of the United States are vitally interested in the enactment of a just and equitable law for this purpose, and realizing that the old law contained many inequities which should be corrected and as all of the physicians and dentists and veterinarians of World War II were discharged on a point system which was generally felt to be most equitable, we therefore, feel that a point evaluation system should be used for the drafting of physicians, dentists, veterinarians and allied specialists into the military services, and

WHEREAS, many county medical societies in the State of Florida, including the Orange County Medical Society, as well as the State Advisory Committee to Selective Service for Physicians have used a point system as near as possible in conformity with Public Law No. 779, and

WHEREAS, there have been many expressions of satisfaction with the point system from the physicians and various committee members, it is generally felt that the point system will meet with satisfaction among the great majority of the physicians in the United States; therefore be it

RESOLVED, that the Orange County Medical Society at its regular monthly meeting March 18, 1953, does hereby approve the point system which is attached hereto and made a part of this resolution, and be it further

RESOLVED, that a copy of this resolution be presented to the Florida Medical Association House of Delegates at the annual convention April 26-29, 1953, for approval and that a copy of this resolution be sent to each senator and member of the House of Representatives from the State of Florida, requesting that such a point evaluation system be enacted into the new law.

Suggestions for Point Evaluation System Proposed

1—AGE
- 1 point for each year, up to 30 years of age and
- 2 points for each additional year, 31-45 years of age and
- 4 points for each additional year, 46 years of age and over

2—MARITAL STATUS
- 6 points if married before 1 June, 1950

3—DEPENDENTS
- 4 points each for children born before 1 March, 1951
- 2 points each for other children
- 2 points for each other absolute dependent

4—MILITARY SERVICE
- 1 point for each month or fraction thereof of active duty
- 1 point additional for each month or fraction thereof of sea duty or overseas duty
- 10 points additional for each month or fraction thereof as a prisoner of war
- 10 points additional for recipients of Purple Heart

5—ASTP and V-12 PERSONNEL
- Deduct 3 points for each month or fraction thereof of training under either category

6—PHYSICIANS DEFERRED TO COMPLETE TRAINING AT OWN EXPENSE
- Deduct 2 points for each month of deferment or fraction thereof

7—(A) Any physician who is able and does carry on an active practice of medicine who has not served in the Armed Forces of the United States as a medical officer in the Medical Corps during World War I or II:
- Deduct 10 points from whatever total he may have for age and dependents

(B) Those men declared essential by the Procurement and Assignment Committee during the last war should not be penalized.

8—This point evaluation system shall be used for the induction of physicians into all branches of the military services, registrants and members of organized Reserve components.

Dr. Herpel: "The resolution on alteration of regulations governing the physical requirements of physicians for entrance into the Armed Services, presented by the Duval County Medical Society is approved.

"I move the resolution be adopted."

Seconded by Dr. Ralph Herz.

Motion carried.

Resolution

PREAMBLE: This resolution is presented in an effort to establish an equitable method of appraising the professional man's ability to perform satisfactory military service. It is thought that the following measures will provide a system and a sequence for induction of physicians into military service which will be fair and just to all.

WHEREAS, Federal Law No 779 (81st Congress, Chapt. 939-2D, Session S-429) designates physicians, dentists and veterinarians as a special category for induction into the Armed Forces, and

WHEREAS, This law specifically provides for entry into the Armed Forces of such men up to the age of fifty years, thus setting them apart from the general draft law, and

WHEREAS, Many eligible physicians able to carry on full, strenuous civilian practices are being exempted from military service because of minor physical ailments thus necessitating recall into the Armed Services many men who have already patriotically served during World War II; many of whom have served considerably longer than the present basic requirement of two years, and

WHEREAS, Men in the military services have been selected because of their youth and their average or above physical and mental fitness, and

WHEREAS, Disability and sickness of these men outside combat zones are likely to be far less than in the average civilian population, and

WHEREAS, Present military requirements were established before the adoption of many present immunizations which have lowered the sickness rate from most communicable diseases to a fraction of its former level thereby lowering the requirements of physicians per man, and

WHEREAS, Medical officers in the services spend an estimated 40 per cent of their time caring for civilian employees and civilian dependents of military personnel thereby unnecessarily increasing the number of doctors called into the services, and

WHEREAS, One physician per 500 civilian population is considered ideal in civilian life, and

WHEREAS, The requirement of two physicians per thousand troops rather than three per thousand as now in force would in large measure eliminate the present unwarranted demand for physicians by the services, and

WHEREAS, There are enough physically qualified physicians eligible for full military services, more limited service medical officers should be utilized in fixed installations, and

WHEREAS, Proper physical and professional classification will do much to insure adequate medical manpower with a minimum of professional waste,

THEREFORE BE IT RESOLVED, By the Duval County Medical Society in Assembly convened that they petition the Congress of the United States to enact legislation providing:

1. For the alteration of existing regulations governing the physical requirements of physicians for entrance into the Armed Services to provide for the induction of *eligible* physicians with physical defects who are able to carry on full-time active practices.

2. That these previously exempted men be called according to the existing plan of priority, so that they will be called *before* the induction of veterans of World War II.

3. That the Voluntary Waiver be eliminated, and if physical disabilities warrant it, such physicians be placed under a limited duty classification similar to that authorized in the Armed Forces Reserve Act (Public Law 476, Sec. 232).

4. That these Limited Service Medical Officers be given duties compatible with their physical condition and their professional training, in other words "Properly Classified."

5. That the number of physicians per thousand troops be limited by law to a realistic rather than an excessive level in consideration of the health needs of our civilian population.

6. That civilian dependents of military personnel and civilian employees of the military services be cared for by civilian doctors where possible, aided by voluntary insurance when practicable.

7. That a basic term of service be established for all physicians to be called the *BASIC SERVICE OBLIGATION*. This basic term should be equal in time for each physician. Any physician's liability for future service should be based upon the completion of an *equal* time in military service by every other qualified physician within the draft limits; and

BE IT FURTHER RESOLVED, That a copy of this resolution be presented to the Florida Medical Association House of Delegates at the Convention to be held in April, 1953, and that a copy be sent to each Senator and member of the House of Representatives from the State of Florida, and to each County Medical Society in Florida and each State Medical Association in the United States.

Respectfully submitted,
John T. Stage, *Secretary*
Duval County Medical Society

This Resolution was adopted by the Duval County Medical Society in assembly convened on Jan. 6, 1953.

Dr. Herpel: "The resolution on evaluation of physical requirements for physicians being called into military service presented by the Escambia County Medical Society is approved.

"I move the resolution be adopted."

Seconded by Dr. Edward R. Annis,

Motion carried.

Resolution

The Escambia County Medical Society, being cognizant of the fact that Public Law 779 is to expire on June 30, 1953, has resolved that this law be re-inacted with a more realistic evaluation of physical requirements for physicians in Groups 1, 2, 3 and 4, so that all physicians, who fall within the age limits of this law, may have an opportunity of fulfilling their patriotic duty to their country. It was the feeling of the Society that any physician capable of performing private practice should be able to engage in some phase of military medicine. It was further resolved that medical care of non-military personnel and government employees, within the continental limits of the United States, should be performed by civilian physicians and civilian institutions wherever feasible, thereby reducing the number of physicians who may have to be called under this law.

It is the desire of the Escambia County Medical Society that this resolution be presented to the Committee on Resolutions of the Florida Medical Association.

Dr. Herpel: "Next is the resolution presented by the Alachua County Medical Society on place of the annual meeting in 1954. I am sure you are all familiar with the articulate minority who express themselves on the fact that we are compelled, and I say compelled advisedly, to meet year after year in this hotel. Throughout all these years, there have been repeated visits made by your Managing Director, your officers, and members of the Board of Governors, all over Florida carefully investigating and going over the facilities available in various localities. The men who have made these surveys have been cognizant of the fact that we would like to be able to spread around over the state, we would like to go to other counties, we would like the Dade and Broward men to go to meetings and not be subject to telephone calls. At the same time, you must realize that there are certain requirements that must be met if we are to have a successful meeting. We are not particularly interested in Hollywood or any other part of the state, but we are interested in the best meeting possible for the Florida Medical Association.

"Therefore the resolution on the question of a meeting place for the annual convention of the Florida Medical Association presented by the Alachua County Medical Society has been carefully considered. The Reference Committee is in sympathy with the viewpoint expressed by the members of the Alachua County Medical Society and believes that it is the sense of the Association that as soon as another city in the state can offer facilities for handling the conventions of this Association, that invitations will be favorably received by the officers. We, therefore, feel that this resolution of the Alachua County Medical Society for the 1954 Annual Meeting cannot be recommended for approval at this time.

"I move the resolution be disapproved and not published in The Journal. I might also say that it is too late to make any change for 1954."

Seconded by Dr. Warren W. Quillian.

The Chair recognized Dr. Burns A. Dobbins, Jr., of Fort Lauderdale.

Dr. Dobbins: "I want to speak for the articulate minority. I assure you that I am in the minority. I want to be the first to admit that the Hollywood Beach Hotel is the finest place in the state to have this meeting, and Broward County is the finest place for many reasons.

"There are many other good places in this state and this is a state organization. Whenever you meet in one place repeatedly, you are going to lose members who will not travel great distances to a meeting. These meetings are to keep the entire membership in touch with the state organization. The Medical District Meetings are not accomplishing that purpose. I think we should seriously consider this problem.

"I realize the difficulties that are entailed in arranging these meetings. I know this hotel offers better convention facilities, particularly for exhibits, but there are other cities which can accommodate them. Of course, not all under one roof, but we cannot do that here now.

"I don't think that just waiting for an invitation will solve the problem. I think we must make some other arrangements for some kind of meeting at some other place. I realize it takes a long time, and probably we should select our meeting place two years in advance. I understand two years from now, if we want this hotel, we will have to have our meeting in May.

"I know we will have to meet here in 1954.

"I move to amend the resolution to the effect that the Board of Governors be directed to find another place for 1955."

Seconded by Dr. Donald W. Smith.

The Chair recognized Dr. Louis M. Orr, II.

Dr. Orr: "I move that we amend the amendment, that the phrase 'direct the Board of Governors' be changed to 'request the Board of Governors to consider another place for the annual meeting.' "

Seconded by a chorus of voices.

Dr. Dobbins: "I do not accept that amendment."

The Chair ruled that the amendment to the amendment must be voted on, and asked for a rising vote.

The Secretary announced the results of the physical count, 72 for, 29 against.

The Chair declared the amendment to the amendment carried.

The Chair then called for a vote on the amendment as amended.

The amendment as amended carried.

The Chair called for a vote on the motion as amended.

Motion carried.

Dr. George W. Morse rose to a point of order.

Dr. McIver: "State your point of order."

Dr. Morse: "I don't think half the people here know what is in the resolution."

The Secretary read the motion as amended.

The Chair ruled that the point of order be not allowed.

Resolution

WHEREAS, the Florida Medical Association has held its annual convention in Hollywood for the past four years,

BE IT RESOLVED, that the Alachua County Medical Society requests the Board of Governors to consider another place for the annual meeting in 1955.

Dr. Herpel: "There are two recommendations of the Board of Governors in their report, which we should consider separately.

"First, the recommendation with respect to the duties of officers is approved.

"I move the adoption of the recommendation of the Board of Governors regarding this change in the By-Laws."

Seconded by Dr. Samuel G. Hibbs.

Motion carried.

Recommendation: That the By-Laws be amended as follows:

Chapter V — Duties of Officers

Sec. 2. The President-elect shall be ex officio member of all regular committees without the power to vote. In the event the President dies, resigns, or is removed from office, the President-elect shall immediately become the President and shall serve for the remainder of the term of his immediate predecessor, as well as continuing as President for the following year. If there is a vacancy in the offices of both President and President-elect, the First Vice President shall act as President until the next annual election.

Sec. 3. The Vice Presidents shall assist the President in the discharge of his duties. They may be assigned specific duties at the discretion and wish of the President.

Delete "Sec. 3" and substitute in lieu thereof, Sec. 4.

Delete "Sec. 4" and substitute in lieu thereof, Sec. 5.

Dr. Herpel: "Next, the recommendation of the Board of Governors that the Hollywood Beach Hotel in Hollywood be designated as the meeting place for the 1954 Annual Meeting is approved."

Dr. Herpel read paragraph 69 of the By-Laws.

Seconded by Dr. Samuel G. Hibbs.

Motion carried.

Recommendation: That the Hollywood Beach Hotel in Hollywood be designated as the meeting place for the 1954 annual meeting. The By-Laws provide that the dates for the meeting shall be set by the Board of Governors.

Dr. Herpel: "The report of the Board of Governors presented by Dr. Robert B. McIver, Chairman, is approved with special commendation to the Sub-Committee on Blue Shield, Dr. Leigh F. Robinson, Chairman, and the Sub-Committee on Review of Fee Schedules, Dr. John D. Milton, Chairman, also to our representatives on the Committee on Medicine and Hospitals. The other recommendations of the Board of Governors have been previously covered.

"I move the report be adopted."

Seconded by Dr. Ralph Herz.

Motion carried.

Report of Board of Governors

Robert B. McIver, *Chairman*

Three meetings of the Board of Governors were held, as follows: April 30, 1952, August 22, 1952. December 13, 1952. At two, out of the three meetings of the Board, every member was present. The faithfulness of the members of your Board to attend meetings at their own expense and time deserves special mention.

Your Board recommends that the By-Laws be amended to provide that the President-elect instead of the First Vice President shall succeed the President, in the event a President dies, resigns or is removed from office. If there is a vacancy in the offices of both President and President-elect, the First Vice President shall act as President until the next annual election. The Vice Presidents shall assist the President in the discharge of his duties. They may be assigned specific duties at the discretion and wish of the President.

See recommendation at the end of this report.

President McIver and the Managing Director made a survey of possible meeting places for the 1954 annual meeting and reported to the Board the facilities in Hollywood, Miami, St. Petersburg and Tampa. After careful consideration, it is the recommendation of your Board that the 1954 annual meeting be held at the Hollywood Beach Hotel, Hollywood, Florida.

See recommendation at the end of this report.

The dates for the Seventy-Ninth Annual Meeting in Hollywood were set for April 26-29, 1953.

An operating budget for the fiscal year beginning April 1952 was presented by Dr. Samuel M. Day, Secretary, and approved.

The schedule to be followed at the Seventy-Ninth Annual Meeting was discussed in detail and approved. Following this schedule, the program was published in the March Journal and in the printed programs handed out at this meeting.

The following members, on recommendation of their local county medical societies, were elected to Honorary Memberships: Drs. Melton D. Council, Francis A. Gowdy, Harry Z. Silverman, Joseph S. Murrow, and John A. Pines.

Your Board designated the Florida Society of Neurology and Psychiatry to make the selection of hospitals, under 1951 General Laws of Florida, Vol. 1, Chapter 26522 (No. 53), House Bill No. 266.

Your Board revised the set-up in connection with the Committee on Medicine and Hospitals (known as COMAH), that this Committee shall consist of 8 members appointed by the following associations: 4 members by the Florida Medical Association; 1, Florida Blue Cross; 1, Florida Blue Shield; 1, Florida Hospital Association; 1, representing the last three named.

The COMAH Committee shall elect a secretary and treasurer. The offices of secretary and treasurer may be held by one individual. It is understood that the Chairman of the F.M.A. Committee on Legislation and Public Policy will serve as Chairman of COMAH Committee. * * * * *No funds shall be disbursed to influence votes in the Legislature. The services of an attorney should be retained for counsel and assistance as required.

The Board's Sub-Committee on Review of Fee Schedules, of which Dr. John D. Milton is chairman, was highly complimented on the work and effort put forth as well as for a good job well done. Many meetings of this subcommittee were held and the time and expense involved traveling over the state was quite unusual.

A letter was received from Mr. C. Joseph Stetler, Secretary, Council on National Emergency Medical Service of the A.M.A. on the problem of placement of physicians returning from military service. The Committee on Advisory to Selective Service, of which Dr. J. Rocher Chappell is Chairman, was designated to handle this assignment.

Your Board approved in principle and referred to Blue Shield and Blue Cross of Florida for their consideration, the resolution of the A.M.A., which reads:

Resolution

WHEREAS, Dependents of members of the armed forces at times need medical care under circumstances that involve financial hardships, lack of adequate governmental facilities, or both; and

WHEREAS, The physicians of the United States through their sponsored prepayment plans are able to provide medical care to such dependents on a service basis; and

WHEREAS, Many citizens entering military service already have protected their dependents against costs of illness through voluntary insurance; and

WHEREAS, Blue Shield and other medically sponsored plans enable their members to receive high quality medical care with free choice of physician; and

WHEREAS, Labor and industry generally have recognized that medical insurance benefits for dependents are important in developing better employee morale; now, therefore, be it

RESOLVED, That, if in the independent judgment of the Department of Defense or Congress, the welfare of our preparedness program requires that dependents of members of our armed forces receive medical care on a service basis, then the medical profession stands ready to provide such services through Blue Shield and other medical society sponsored plans.

★ ★ ★

Sub-Committee to Board of Governors on Blue Shield

In many ways 1952 was an outstanding year. Blue Shield increased its membership during the year by 53,323 people, bringing the total covered as of December 31st to 270,012. During the year we paid 40,411 cases, amounting to $1,757,754.75. This is an increase of 4,132 cases over the year 1951 and an increase in payments to doctors over 1951 of $173,845.99. Of the cases, 35,021 were surgical cases, 5,390 were medical cases, involving 37,028 patient days.

Leigh F. Robinson, *Chairman*

Sub-Committee to Board of Governors on Review of Fee Schedules

The Sub-Committee to the Board of Governors on Review of Fee Schedules is proud to announce the fact that during the past year there has been a complete revision of the Veterans Administration Fee Schedule, the Industrial Commission Fee Schedule, a revised Fee Schedule for Blue Shield, and finally, the Medical Advisory Committee to Vocational Rehabilitation has approved the new Fee Schedule of the Veterans Administration as a guide. The Committee, as a whole, feel that this is a great step forward by getting away from the fixed fees of fifteen to twenty years ago.

I wish to take this opportunity to thank the Board of Governors, the Florida Association of Industrial and Railway Surgeons, and all other specialty groups that contributed to the success of this Committee's work, and last, but not least, I wish to thank each individual member for his untiring efforts in getting the approvals of the schedules as stated above.

John D. Milton, *Chairman*

Respectfully submitted,
Robert B. McIver, *Chairman*

Dr. Herpel: "The report of the Committee on Public Relations presented by Dr. Eugene B. Maxwell, Chairman, is approved with commendation to Dr. Maxwell and his committee for a fine year's work.

"I move the report be adopted."

Seconded by Dr. Alvin L. Stebbins.

Motion carried.

Report of Committee on Public Relations

Eugene B. Maxwell, *Chairman*

The work of this Committee has been to promote the overall Public Relations Program of the Association with special emphasis on the Rural Educational Program and Fair Exhibits which were added during 1951.

In behalf of the Rural Educational Program, physician speakers appeared on the programs of the Farm and Home Institutes sponsored by the Florida Agricultural Extension Service of both state universities for persons throughout the northern part of the state. Illustrations used by these physicians in presenting their addresses were requested for showing at the annual state conference of county and home demonstration agents at Gainesville.

Literature and health posters supplied by the Committee and stamped "Distributed jointly by the Florida Medical Association, county medical societies and Florida Agricultural Extension Service" have been distributed by county and home demonstration agents throughout the year.

Five county medical societies applied for the Florida Medical Association's exhibit prior to beginning of the 1952-53 fair season for showing at fairs in their areas. Conflicting dates prevented all requests from being filled.

Following the schedule worked out with the assistance of county medical society officers, showings have been held at the North Florida Fair at Tallahassee and the Central Florida Exposition at Orlando. Sponsoring the exhibit at Tallahassee was the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society and at Orlando, the Orange County Medical Society.

Offered to the public without charge at each showing have been blood pressure determinations and blood grouping and typing. Recorded as taking advantage of this service were 12,667 persons. This figure does not include the total from the Central Florida Exposition. It does include the number of persons passing through the exhibit at the 1952 Florida State Fair, Tampa.

More than 60,000 pieces of literature were distributed to these persons. Each piece had been stamped "Courtesy of the Florida Medical Association." In addition, each person having his blood typed or pressure taken was given a card with the information recorded and on which had been printed "Florida Medical Association."

A display based on the fair exhibit was shown during the Public Relations Institute held by the American Medical Association in Chicago.

Upon request from the Putnam County Medical Society, arrangements were made for two health exhibits for display by the Society at the Putnam County Fair, Palatka.

Seventeen radio stations have been broadcasting from every section of the state transcribed medical programs supplied by the Association and sponsored by the local county medical societies. Through December, 1952, a total of 76 sets of these transcriptions had been used. This represents 247 hours of continuous broadcast time.

The feature "Health Topics" prepared especially for weekly newspapers are being distributed to 78 papers; 65 papers are publishing the releases.

Upon invitation, the display assembled for the annual meeting at Hollywood was set up at the meeting of the Southern Medical Association in Miami for showing to physicians from throughout the South.

The essay contest among junior and senior high school students was conducted again this year in cooperation with the county medical societies.

Continual contact has been maintained with newspapers, radio and television stations, civic and allied organizations and influential individuals to bring about a closer relationship between the medical profession and the citizens of Florida.

Florida medicine has continued to maintain national recognition from a Public Relations standpoint and has a right to be proud. However, the need for a continued and deep rooted program is greater than ever and I trust great strides will be made during these next few years while we have a healthier atmosphere to work in.

Members of the Committee on Public Relations extend their appreciation to all county medical societies and to the staff of the Bureau of Public Relations for utmost cooperation and assistance during the past year.

Respectfully submitted,
Eugene B. Maxwell, *Chairman*

Dr. Herpel: "The report of the Committee on Emergency Medical Service, Dr. James V. Freeman, Chairman, was not presented, therefore, no action is necessary.

"The report of the Committee on Necrology is regretfully accepted, with the following amendment: "During the last fiscal year, our Association lost by death the members whose names are listed below, and Dr. Stewart G. Thompson, Jacksonville, our Managing Director.

"I move the report be adopted as amended."

Seconded by Dr. Shaler Richardson.

The House of Delegates stood for a moment of reverent silence.

Report of Committee on Necrology

Alvin L. Stebbins, *Chairman*

During the last fiscal year our Association lost by death the members whose names are listed below:

C. LeRoy Adams, Jr., Live Oak
James M. Anderson, Cross City
Robert Blessing, Fort Lauderdale
James W. Brantley, Grandin
George H. Carefoot, Fort Meade
George W. Carter, Chipley
Charles A. Clemmer, Ormond Beach
Adrian C. Coogler, Brooksville
Charles S. Early, Lakeland
M. M. Harrison, Bradenton
Milton B. Kay, Miami Beach
Arthur J. Logie, Miami
Frank J. McKinley, Tampa
Herbert R. Mills, Tampa
W. Duncan Owens, Warrenton, Va.
Henry E. Parnell, Perrine
Wilson C. Pay, DeLand
Charles H. Petteway, Lakeland
James C. Richardson, Miami
Samuel F. Ricker, Orlando
Leo H. Riesenbeck, Miami

Francis S. Skiff, Fort Lauderdale
Herbert E. Sperry, Coral Gables
W. Henry Spiers, West Palm Beach
A. D. Stollenwerck, Jacksonville
Joseph E. Taylor, DeLand
Binford Throne, Bradenton
George C. Tillman, Clearwater
William H. Weems, West Palm Beach
Harold E. Winchester, Dunedin

Supplement

Henry B. Cordes, Frostproof
N. J. Dawkins, Vernon
Ellis W. Holloway, Tampa
Daniel A. McKinnon, Marianna
Walter G. Miles, Chattahoochee
Thomas J. Moore, St. Petersburg
George A. Paulk, Miami
Joseph Perez, DeLand
John A. Simmons, Arcadia
Walter Wilkins, Jacksonville

and Stewart G. Thompson, Jacksonville, our Managing Director

When possible, obituaries have appeared in The Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

May we at this time stand for a moment of silence in reverence and respect to the memory of our departed colleagues.

Respectfully submitted,
Alvin L. Stebbins, *Chairman*

Dr. Herpel: "The report of the Committee on Advisory to Woman's Auxiliary presented by Dr. C. Robert DeArmas, Chairman, is approved.

"I move the report be adopted."

Motion duly seconded and carried.

Report of Committee on Advisory to Woman's Auxiliary

C. Robert DeArmas, *Chairman*

The Committee on Advisory to the Woman's Auxiliary to the Florida Medical Association had no occasion for holding a formal meeting during the year. The question of soliciting an advertisement in "Medaux," Woman's Auxiliary publication, came up and was satisfactorily resolved. No further communications have been received.

Respectfully submitted,
C. Robert DeArmas, *Chairman*

Dr. Herpel: "The report of the Committee on Councilor Districts and Council presented by Dr. Eugene G. Peek, Jr., Chairman, is approved.

"I move the report be adopted."

Seconded by Dr. Walter C. Payne.

Motion carried.

Report of Council

Eugene G. Peek, Jr., *Chairman*

Your Council is pleased to report that no unusual problems were faced during the past year. No new component societies were organized. The few counties at present unorganized are Santa Rosa, Baker, Hamilton, Dixie, Lafayette, Bradford, Gilchrist, Union, Clay, Levy, Sumter, Osceola, and Flagler, as there are not sufficient members in these counties to warrant independent county organizations. All of the counties named are under the supervision and aid of organized county medical societies until such time as they should be designated individual organizations.

Each Councilor has made an effort to visit county societies in his Councilor District and the activities in each local society appear to be functioning properly.

A meeting was held in each of the four medical districts in October, 1952 at Panama City, St. Petersburg, Fort Pierce and Daytona Beach at 2:30 p.m.

At each of these meetings, two scientific papers were presented and the Association's officers delivered short addresses. The two Councilors in each medical district assisted the Chairman in arranging the programs and presiding at the meetings.

Many members who are not able to attend the Association's Annual Convention were present and had an opportunity to personally meet and chat with the officers of the state Association. The esprit de corps at these informal district meetings is an influence for increasing the attendance.

The Woman's Auxiliary to the Florida Medical Association, under the leadership of Mrs. Herschel G. Cole, arranged work-shop meetings for the ladies during the afternoon and joined the doctors for the dinner and evening session on legislation.

I would like to acknowledge Stewart G. Thompson, without whose splendid cooperation this Chairmanship would have been a burden. We are all very fortunate to have a man such as Stewart as a Managing Director of the Florida Medical Association. I would like also to thank Dr. Samuel M. Day and Harold Parham for their cooperation during the District Meetings.

This report is brief as there was a complete write-up on the Medical District Meetings in your January 1953 Journal, page 524.

Respectfully submitted,
Eugene G. Peek, Jr., *Chairman*

Dr. Herpel: "The report of the Committee on Advisory to Selective Service for Physicians and Allied Specialists, presented by Dr. J. Rocher Chappell, Chairman, is approved with special commendation to the able chairman and members of this committee. It is further recommended that Dr. Chappell be designated as a representative of the Florida Medical Association before the Armed Services Committees of Congress if an invitation to appear is extended to him."

"I move the report be adopted."

Seconded by Dr. Ralph Herz.

Dr. Thomas H. Bates asked for an explanation.

Dr. Herpel: "Hearings on the new bills are being held within the next ten days. Dr. Chappell has had one invitation, but could not go. In case he gets another invitation, the committee has recommended that he be appointed to that position."

Motion carried.

Report of Committee on Advisory to Selective Service for Physicians and Allied Specialists

J. Rocher Chappell, *Chairman*

Submitted herewith is the annual report of the Committee on Advisory to Selective Service for Physicians and Allied Specialists. This is a statistical report of the entire registration of Priority I, II, III physicians and their present status as of December 31, 1952.

Priority I

Total Special Registrants	148
1-A and 1-A-O — examined and acceptable	5
1-A and 1-A-O — not examined	6
1-C — extended active duty	52
1-C — Reserve	3
1-D — Reserve not yet called	28
2-A — Essential	14
4-F —	40

Priority II

Total Special Registrants	42
1-A and 1-A-O — examined and acceptable	2
1-A and 1-A-O — not examined	1
1-C — extended active duty	7
1-C — Reserve	1
1-D —	8
2-A —	6
3-A —	2
4-F —	15

Priority III

Total Special Registrants	416
1-A and 1-A-O — examined and acceptable	51
1-A and 1-A-O — not examined	162
1-A — postponed	1
1-C — extended active duty	3
1-D —	1
2-A —	68
3-A —	3
4-F —	111
5-A —	16

Explanation of Classification of Special Registrants

1-A and 1-A-O	Number presently classified in a class available for military service who have been found acceptable by armed forces physical examination. Some of these registrants are presently under an order to report for induction.
1-A and 1-A-O (not examined)	Number of registrants classified as available for military service who have not yet been reported as acceptable or not acceptable for service. The majority of these registrants have been forwarded for examination, however, the results were not known as of December 31, 1952.
1-A (postponed)	Registrants classified 1-A whose induction has been postponed by his local board for reasons in accordance with the Regulations.
1-C	Registrants who are presently serving on active duty in the Armed Forces.
1-C-Reserve	Registrants who entered active duty subsequent to the date fixed for registration and who have been released to inactive duty.
1-D	Registrants who are members of Reserve components of the Armed Forces who have not yet been called to active duty.
2-A	Registrants who have been deferred by reason of essentiality.
3-A	Registrants who have been deferred by reason of hardship.
4-F	Registrants who have been found disqualified for military service.
5-A	Registrants who have reached the age of 51 years.

The latest advice from the National Advisory Committee in Washington indicates that Priority III registrants will be called to active duty in age groups, the youngest groups will be called first.

Group I — this group will include those physicians under thirty years of age and at the maximum not more than four years out of medical school.

Group II — this group will include those physicians from thirty to thirty-four years of age. These will have obtained their medical education for the most part during World War II being for various reasons deferred.

Group III — this group will comprise those men thirty-five to thirty-nine years of age. These physicians while receiving their medical education previous to World War II were sufficiently close to it so that they might have been expected to have served in that war rather than to have entered into practice.

Group IV — this will include physicians from forty years of age to forty-four who had, in general, been in practice fifteen to twenty years previous to the onset of World War II.

Group V — this will include those physicians from forty-five to forty-nine years of age. This is the largest group of all.

Group VI — this will include those men who are fifty years of age or over but whose vulnerability ceases at fifty-one.

This concludes our report for the year 1952, and, on behalf of my Committee, I would like to say thank you to all the members of our county committees who have so faithfully responded when called upon by your state Chairman.

Respectfully submitted,
J. Rocher Chappell, *Chairman*

Recommendation

The Reference Committee recommends that Dr. Chappell be designated as a representative of the Florida Medical Association before the Armed Services Committees of Congress if an invitation to appear is extended to him.

Dr. McIver: "I would like to express my personal appreciation to these three hard-working reference committees. They have gone over and thrashed out all these problems. That is what makes this meeting such a pleasure to all present. Having a fight on the floor of the House is no fun, but if we have a sharp difference of opinion in the Reference Committee, it can be straightened out there.

"At this time also, I would like to express by sincere appreciation to the parliamentarian of my personal choice, Dr. Joseph S. Stewart.

"Before I call for any unfinished business, I would like to request that the President of the Past Presidents make his report."

Dr. William M. Rowlett: "President McIver, Members of the House of Delegates, the Board of Past Presidents wishes to congratulate the Committee on Scientific Work for their splendid program and the best attendance in the history of the Association.

"It is suggested by the Board of Past Presidents, that the Board of Governors consider the advisability of holding the Association's Annual Meetings on Thursday, Friday and Saturday, with the specialty groups holding their meetings Saturday afternoon and Sunday instead of holding the annual meeting on Monday, Tuesday and Wednesday with the specialty groups holding their meetings on the preceding Saturday and Sunday."

Dr. McIver: "Unless there is a contrary opinion, we will refer this to the Special Committee on Scientific Assembly and Specialty Group Problem, which was appointed last year, of which Dr. Herbert E. White is Chairman."

"I am advised that if there is a motion to suspend the rules, so that the election of officers may be held, this may be done by a two-thirds vote of the delegates present."

Dr. Herbert L. Bryans: "I move that the rules be suspended so that the election of officers may proceed immediately."

Seconded by Dr. Karl B. Hanson.

Motion carried.

The Chair recognized Dr. William C. Roberts of Panama City.

Dr. Roberts: "President McIver, Members of the House of Delegates, you have seen how Bob's sturdy ship of the Florida Medical Association has been pounded and rocked. We can't let that go on too long — we have to keep it on an even keel. I know all of you realize that the Florida Medical Association may be in for some rough weather. All of you know that the man who was known as "Mr. Florida Medical Association" is gone. We have got to try to replace him somehow, so you have to do it with the right man. If you heard your President's address, he told you that we should be vigilant, we cannot be complacent, we have to stay on the ball all the time. You heard your Legislative Chairman report on current legislative problems. You realize, with all these things in view, we have to have someone to head your Association who knows. The man I have in mind knows the Florida Medical Association. The man is qualified to the ground. He is deserving to the hilt. With these facts in mind, I would like to nominate for President-elect of the Florida Medical Association, Dr. Duncan T. McEwan of Orlando."

Dr. Frank J. Pyle: "You all know that actions speak louder than words. I am sure you all agree that the many activities of Dr. Duncan McEwan in this Association say more than I can say to you with a few words. The Orange County Medical Society endorses Dr. Duncan McEwan 100 per cent and it is a privilege for me to second this nomination for Dr. McEwan."

Dr. Herbert L. Bryans: "It is a privilege and a pleasure for Escambia County Medical Society to second the nomination."

Dr. Thomas H. Bates: "I am one of those men who comes from one of the small societies but whose membership is deeply interested and always has been. It is my privilege, on behalf of the Columbia County Medical Society to second the nomination of Dr. Duncan McEwan."

Dr. Alvin L. Mills: "The Pinellas County Medical Society would like to second the nomination of Dr. McEwan."

Dr. Jelks: "I move that nominations be closed."

Seconded by Dr. Henry L. Harrell.

Motion carried.

The Chair instructed the Secretary to cast the ballot for Dr. McEwan.

Dr. McIver: "Duncan, let me be the first to congratulate you. We would like to have you say a few words."

Dr. McEwan: "Thank you very much, friends. It is a definite honor to be elected as President-elect of our great Association. I also want to accept this as an honor for Orange County and Central Florida. I consider it an honor for all those members we have had in Central Florida who have done so much work, and accepted the responsibility. I promise that I will do my best for our Association. Thank you very much."

Dr. McIver: "Nominations are now in order for the office of First Vice President."

Dr. John D. Milton: "Chairman and Delegates, in making this nomination I am not unmindful of the fact that there are many, many men in the Association who are good timber for First Vice President, but this man I wish to nominate is a man who is well known throughout the Florida Medical Association, is a man well loved by all, is a man who has worked in the Association for many, many years. He is a man from a small county, a man who does general work and has been on your Board of Governors. I take pleasure in nominating Dr. Thomas H. Bates of Columbia County."

Seconded by Dr. Herbert L. Bryans and Dr. Alvin L. Mills.

Dr. Walter C. Payne: "I move that nominations be closed."

The motion was duly seconded and carried.

Dr. McIver: "The Secretary will cast the ballot for Dr. Bates.

"Nominations are now in order for the office of Second Vice President."

Dr. Frederick H. Bowen: "Mr. Chairman, Members of the House of Delegates, in the years we have been coming down here, our entertainment has been handled largely by one man. He

put on a good show downstairs, and I even played my banjo, then he put on an excellent water show at the pool, then the other night, he made it possible for us to learn roulette and a lot of other games at a cost of only $2.50. I would like to place in nomination for the office of Second Vice President, Dr. Russell B. Carson."

Dr. David R. Murphey, Jr.: "I move that nominations be closed."

Seconded by Dr. Alvin L. Mills.

Motion carried.

Dr. McIver: "The Secretary will cast the ballot for Dr. Carson.

"Nominations are now in order for the office of Third Vice President."

Dr. V. Marklin Johnson: "I nominate for the office of Third Vice President, Dr. Thomas C. Kenaston."

Dr. C. Frank Chunn moved that nominations be closed.

Seconded by Dr. Samuel G. Hibbs.

Motion carried.

Dr. McIver: "The Secretary will cast the ballot for Dr. Kenaston.

"Nominations are now in order for the office of Secretary-Treasurer."

Dr. Jere W. Annis: "It becomes my perennial privilege to replace in nomination for this office, the name of Dr. Sam Day. With the loss of our beloved Managing Director, I think it is more and more important that we have someone in the office of Secretary-Treasurer, who can tell Joe Stewart to tell Bob McIver to tell Fred Herpel what to do."

Dr. John D. Milton moved that nominations be closed.

Seconded by Dr. Samuel G. Hibbs.

Motion carried.

Dr. McIver: "The President will take pleasure in casting the ballot for Dr. Day.

"Nominations are in order for the office of Editor of The Journal."

Dr. Alvin L. Stebbins: "I would like to have the pleasure of nominating Dr. Shaler Richardson."

Dr. John D. Milton moved that nominations be closed.

Seconded by Dr. Karl B. Hanson.

Motion carried.

The Chair instructed the Secretary to cast the ballot for Dr. Richardson.

Dr. McIver: "Will Dr. Ed Jelks and Dr. Homer Pearson escort Dr. Herpel to the rostrum?

"Dr. Herpel, I have served this Association for a long time and I would hate to turn this gavel over to a man of small ability but I appreciate the fact that I am transferring this responsibility to one who is greater than the incumbent and under whose leadership we can expect great things. This gavel which you are receiving from this Association is made of the hard wood which represents the strength of the organization. It is bound with sterling silver with your name engraved, which represents the sterling qualities of your character, and it gives me a great deal of pleasure to turn this office over to you."

Dr. Herpel: "I hope I will wield this gavel with discretion.

"Delegates and Members of the Florida Medical Association, Guests, Ladies and Gentlemen, I am deeply conscious, at this moment, of the very great honor which you have paid me in electing me to the office of President. I am both proud and humble. I am humble in the realization of my limitations and the added realization of the responsibilities which are incumbent on the performance of the functions of your president.

"At this time, I must express my very real sense of personal loss in the recent illness and death of Dr. Stewart Thompson, whom we have all come to look upon as a fixture of the Association's staff, and the guiding genius of our annual convention. Mere words cannot convey to you our deep appreciation for the many years of unselfish service which he devoted to the affairs of this Association. Let us all in the same unselfish spirit of service and cooperation, combine together as workers for the good of medicine in Florida.

"Singly I can hope to accomplish very little, but with your able and devoted assistance, and your advice and counsel, we can hope to advance a little toward our goal during this coming year.

"I am encouraged, knowing that we have a capable administrative staff, an able Board of Governors, and able chairmen of the various committees of the Association, as well as a large number of consistent workers for the advancement of the Association among the working majorities of these committees. Together, and with concerted effort, we can make constructive advances in the techniques of the practice of medicine in this state and advance our status in the eyes and hearts of the citizens of Florida, who are our primary responsibility in matters of health and medical care,

and to whom we must ultimately make our accounting.

"Again I thank you for the honor which you have paid me. I shall do my best to justify the trust which you have placed in me.

"And now it is my great pleasure to present to the outgoing president of the Association, Dr. Robert B. McIver, the Past President's pin of the Florida Medical Association, and our Certificate and Scroll of Honor. One might variously interpret the significance of the colors represented in this badge of honor and service. Let us assume that they represent courage (courage to do the thing which seems right even in the face of opposition); devotion (devotion to the high ideals which have, and will, dominate the practice of medicine); purity (purity of purpose and clarity of thought in interpreting the needs of our profession, divorcing one's self from any selfishness in point of view, taking action for the good of the Association as a whole rather than for the advantage of any section or component thereof).

"Dr. McIver, you have rendered over the years signal service to this Association. Your term as president has been but a continuance of the fine service which has always characterized your membership. We congratulate you on the accomplishments of your term as president, and are happy to present to you this emblem, signifying your immediately present status as Past President of the Florida Medical Association and this Certificate of Honor as a small token of our appreciation.

"God be with you, and your good wife, as you enter into the status of a past president. You join a company of distinguished physicians, and still devoted servants of this Association. I ask them to take you into their group of distinguished elder statesmen and advisors, as a member of which I feel certain that you will render long added service to the Association."

Dr. McIver: "Herbert White tried to make a speech at this point and broke down and cried. I will just say, thank you very much."

Dr. Herpel: "By special consent of the Board of Governors, and with perhaps a little inconvenience to one or two of them, we have agreed to allow a meeting of Blue Shield to take place immediately after the adjournment of the House of Delegates. The Board of Governors will meet in room 546 approximately at one o'clock. Luncheon will be served to the Board of Governors and we will immediately go into the first meeting of the new year.

"Dr. Duncan McEwan as President-elect will enter on a new status as a member of the Board of Governors and will please be present at this meeting.

"May I, as my first official act, again compliment everyone who has had anything to do with this meeting of the Association, which is one of the biggest and best we have had yet. I cannot stress enough the work of all the committees. Many have done splendid work. I feel we have come to lean too much on our Managing Director and many of the activities which are the responsibility of chairmen of committees have been allowed to go by the board because Stewart has assumed them. He simply took on his shoulders an increasing burden of work. That work now must be turned back to the members of the Association and its committees. I pledge my earnest effort not only to try to carry out routine duties, but to try to stimulate the activities of each committee in making this one of the finest medical associations in the country. We have gone a long way, but haste makes waste and we must make haste slowly."

There being no further business, on motion from the floor, duly seconded and carried, the House of Delegates adjourned, sine die, at 12:05 p.m.

THE EIGHTIETH ANNUAL CONVENTION

of the

FLORIDA MEDICAL ASSOCIATION

HOLLYWOOD BEACH HOTEL APRIL 25-28, 1954

SCIENTIFIC ASSEMBLIES

First Scientific Assembly

The first Scientific Assembly convened at 9:45 a.m., Monday, April 27, in the Mardi Gras Room with Dr. Frederick K. Herpel of West Palm Beach presiding. The following papers were read and discussed:

"Pheochromocytoma," M. Eugene Flipse, Miami.

Dr. Samuel M. Day: "In honor of our beloved Managing Director who just passed away and whose funeral will take place in a few minutes, we will pause for a moment of silent prayer in his memory."

"Cholesteral, Lipoproteins and Atherosclerosis: Present Concepts," Dale L. Groom, Coral Gables.

"Some Unsolved Problems in Industrial Surgery," Henry C. Marble, Boston.

"Prevention and Treatment of Anesthetic Accidents," Harold Carron, Tampa.

"Cause and Treatment of Non-union of Tibial Fractures," Guy A. Caldwell, New Orleans.

Second Scientific Assembly

The second Scientific Assembly convened at 2:00 p.m., Monday, April 27, in the Mardi Gras Room with Dr. Jere W. Annis of Lakeland presiding.

The following papers were read and discussed:

"The Treatment of Post-Thrombophlebitic Changes in the Legs by Various Surgical and Conservative Means," Frederick H. Bowen, Jacksonville.

Dr. Annis recognized the President of the Association, Dr. Robert B. McIver, who introduced Dr. George F. Cahill, President of the American Urological Association, who read the next paper.

"Hematuria, Its Pathological Significance," George F. Cahill, New York.

"Indications for Surgery in the Treatment of Pulmonary Disease," Hawley H. Seiler, Tampa.

"The Surgical Treatment of Cervical and Fundal Malignancies," Joseph H. Pratt, Minneapolis.

"Tracheo-esophageal Fistula with Atresia of the Esophagus," Ashbel C. Williams, Hugh A. Carithers and Nathan Weil, Jr., Jacksonville.

Third Scientific Assembly

The third Scientific Assembly convened at 2:30 p.m., Tuesday, April 28, in the Mardi Gras Room with Dr. James N. Patterson of Tampa presiding. The following papers were read and discussed:

"Ultrasonic Therapy: A Review of Its Present Status and Future Possibilities," Kenneth Phillips, Miami.

"Therapeutic Research with Radioisotopes," Marshall Brucer, Oak Ridge, Tenn.

"Treatment of Poisonous Snake Bites," Edwin H. Andrews, Gainesville.

"Indications for Insulin in Diabetes Mellitus," H. Phillip Hampton, Tampa.

"Adult Gaucher's Disease Complicated by Thrombocytopenic Purpura and Pregnancy," William P. Logan, Lakeland.

Fourth Scientific Assembly

The fourth Scientific Assembly convened at 9:00 a.m., Wednesday, April 29, in the Mardi Gras Room with Dr. James N. Patterson of Tampa presiding. The following papers were read and discussed:

"Southern Florida and the Cardiac," Sidney Davidson, Lake Worth.

"Hexamethonium Therapy in Hypertension," John S. McMichael, London, England.

REGISTRATION

The registration for the Seventy-Ninth Annual Meeting at Hollywood surpassed that of any previous convention of the Association. The total number registered was 1,725. The registrants included 827 members of the Association, 267 visiting physicians, 17 other guests, 390 members and guests of the Woman's Auxiliary, and 224 representatives of exhibiting firms. There were 26 other states, Costa Rica, Canada, England, and Spain represented.

Registration List

Officers

Robert B. McIver, President	Jacksonville
Frederick K. Herpel, President-elect	West Palm Beach
Francis H. Langley, 1st Vice Pres.	St. Petersburg
Erasmus B. Hardee, 2nd Vice Pres.	Vero Beach
H. Quillian Jones, 3rd Vice Pres.	Fort Myers
Samuel M. Day, Sec'y-Treas.	Jacksonville
Shaler Richardson, Editor	Jacksonville

Members

APOPKA: Thomas E. McBride. ARCADIA: F. Erwin Daves, Charles H. Kirkpatrick, Gordon H. McSwain. AVON PARK: Hubert W. Coleman, Donald C. Hartwell. BARTOW: Milo H. Holden. BELLE GLADE: Eugene E. Christian, (Col.), Wilbert O. Norville, (Col.), Ralph L. Pipes. BRADENTON: Alva J. Floyd, Joseph B. Ganey, Willis W. Harris, John S. Neill, Millard P. Quillian, William D. Sugg, Willett E. Wentzel. BROOKSVILLE: S. Carnes Harvard. BUNNELL: John M. Canakaris.

CHATTAHOOCHEE: John T. Benbow. CLEARWATER: M. Eldridge Black, Raymond H. Center, James C. Fleming, Julio J. Guerra, V. LeRoy Hagan, Everett M. Harrison, Francis C. Hoare, Harvey J. Howard, George H. Schoetker. CLEWISTON: Henry W. Shupe. COCOA: Thomas C. Kenaston. CORAL GABLES: A. Daniel Amerise, Gunnard J. Antell, Ira K. Brandt, E. Hampton Bryson, Henry H. Caffee, Philip J. Chastain, Jack Q. Cleveland, Anna A. Darrow, Franklin J. Evans, Morton M. Halpern, Glenn H. Heller, Jim S. Jewett, C. Howard McDevitt, Jr., Wayne B. Martin, Jerome A. Megna, Joseph R. Morrow, James H. Putman, Warren W. Quillian, T. D. Sandberg, William P. Smith, Rollin D. Thompson, Martiele Turner, Franklyn E. Verdon, Karl W. Vetter, William L. Wagener, Jr., Arthur H. Weiland, Hillard W. Willis, Oliver P. Winslow, Jr., Bernard Yesner. DANIA: Fred E. Brammer. DAYTONA BEACH: John J. Cheleden, James W. Clower, Jr., Cleland D. Cochrane, Bruce Cominole, Hugh Crawford, C. Robert DeArmas, Peter A. Drohomer, James B. Glanton, David W. Goddard, George M. Green, Carroll V. Herron, Herbert A. King, Joel V. McCall, Jr., George H. McSwain, James D. Moffett, Jr., Achille A. Monaco, Howard W. Reed, Joseph H. Rutter, Morris B. Seltzer, Ludo von Meysenbug, J. Richard West. DEFUNIAK SPRINGS: William D. Cawthon.

DELAND: Robert O. Burry, Matthew A. Moroz, Frank Valentine. DELRAY BEACH: Graham W. King, Jr., James R. Nieder, Charles A. Robinson. DUNEDIN: John A. Mease, Jr., James H. Miller, Jr., Walter H. Winchester. EUSTIS: C. McK. Tyre. FERNANDINA: Benjamin F. Dickens. FORT LAUDERDALE: Edward A. Abbey, Curtis D. Benton, Jr., Miles J. Bielek, Robert E. Blount, Oliver C. Brown, Mark Butler, Milton N. Camp, Russell B. Carson, Alfred E. Cronkite, Frank Denniston, Burns A. Dobbins, Jr., Frederick J. Driscoll, Robert L. Elliston, Roland F. Fisher, Richard L. Foster, Donald H. Gahagen, Walter J. Glenn, Jr., Francis Haberman, George Hamerick, Jr., Benjamin F. Hart, Anne L. Hendricks, Wilks O. Hiatt, Jr., Thomas F. Huey, Jr., Paul W. Hughes, Garland M. Johnson, M. Austin Lovejoy, Lloyd U. Lumpkin, Thomas L. McKee, Richard A. Mills, Robert U. Moersch, Albert A. Parrish, Henry J. Peavy, Sr., William K. Peck, Claus A. Peterson, Francis D. Pierce, Raymond M. Price, George M. Rhodes, Jr., Thomas L. Roberts, Jr., Leigh F. Robinson, Vincent V. Smith, Curtis H. Sory, Alva R. Taylor, Willard M. Taylor, Charles L. Wadsworth, James M. Weaver, William D. Wells, Scottie J. Wilson.

FORT MYERS: Fred D. Bartleson, Joseph D. Brown, Angus D. Grace, William H. Grace, Joseph L. Selden, Jr., John S. Stewart, Harvie J. Stipe. FORT PIERCE: Francis A. Gowdy, Adrian M. Sample, Richard F. Sinnott, Lester L. Whiddon. GAINESVILLE: Edwin H. Andrews, Henry S. Blank, J. Maxey Dell, Jr., Albert G. Love, IV, James M. McClamroch, John E. Maines, Jr., Walter E. Murphree, George H. Putnam, Glenn O. Summerlin, Winston L. Summerlin, I. Irving Weintraub. GROVELAND: John D. Bloom. GULFPORT: James M. Neill. HAINES CITY: Emmett E. Martin. HIALEAH: Albert W. McCorkle.

HOLLYWOOD: Thomas S. Adams, Dale T. Anstine, Alexander H. Bluestone, Manuel G. Carmona, Gordon B. Carver, Robert H. Farringer, Bertram J. Frankel, William J. Gallo, Robert R. Harriss, Maxwell M. Hartman, John R. Hege, Jr., Elbert McLaury, Charlotte E. Mason, Bernard Milloff, Louis J. Novak, Robert J. Patterson, Frances E. M. Read, Bernard B. Seltzer, Ernest E. Serrano, Randall W. Snow, George P. Sorvas, S. Elliott Wilson. HOWEY-IN-THE-HILLS: Fred A. Vincenti. HOMESTEAD: Joseph H. Shain.

JACKSONVILLE: Archie J. Baker, S. James Beale, John B. Black, Frederick H. Bowen, Charles W. Boyd, William H. Brooks, John R. Browning, Edward Canipelli, Cornelia M. Carithers, Hugh A. Carithers, Turner Z. Cason, William H. Chapman, Silas M. Copeland, George A. Dame, Simon D. Doff, Lucien Y. Dyrenforth, Joseph A. J. Farrington, Frank L. Fort, Eugene M. Frame, James V. Freeman, A. Judson Graves, Karl B. Hanson, William G. Harris, Luther W. Holloway, Victor A. Hughes, Floyd K. Hurt, Gordon H. Ira, Edward Jelks, Raymond R. Killinger, F. Gordon King, Camillus S. L'Engle, Jr., Thomas H. Lipscomb, John F. Lovejoy, Joseph J. Lowenthal, James G. Lyerly, William H. McCullagh, John M. McDonald, Charles B. Mabry, Milton C. Maloney, Webster Merritt, John H. Mitchell, Bernard L. N. Morgan, Thomas E. Morgan, A. Sherrod Morrow, Matthew E. Morrow, Nelson A. Murray, G. Frederick Oetjen, Lorenzo L. Parks, Benjamin J. Philips, Jr., Ferdinand Richards, Wade S. Rizk, W. W. Rogers, Mason Romaine, III, William E. Ross, Robert G. Rosser, Jr., Joseph H. St. John, Lauren M. Sompayrac, Wilson T. Sowder, John T. Stage, Sidney Stillman, George M. Stubbs, Wilbur C. Sumner, J. Champneys Taylor, Daniel R. Usdin, William A. Van Nortwick, Frederick J. Waas, Edward C. Watt, Nathan Weil, Jr., Ashbel C. Williams, J. Frank Wilson, Richard A. Worsham.

KEY WEST: Ralph Herz, Herman K. Moore. KISSIMMEE: Eugene R. Speirs. LAKE CITY: Thomas H. Bates. LAKELAND: Jere W. Annis, Fred S. Gachet, Ralph B. Hanahan, Marion W. Hester, William A. Hodges, Jr., William S. Johnson, John M. Kibler, Coy L. Lay, Chester L. Nayfield, Louis J. Polskin, T. Hugh Roberts, James T. Shelden, Wylie L. Tillis, S. L. Watson, John W. Williams. LAKE WALES: Edward C. Burns, Jr.,

Harry F. Rolfes, John P. Tomlinson, Jr. LAKE WORTH: Grady H. Brantley, Sidney Davidson, Alva L. Rowe, A. Scott Turk, Edward W. Wood.

LARGO: Helen I. Grove, William A. Leone. LEESBURG: George E. Engelhard, Marion B. O'Kelley. LIVE OAK: Irby H. Black, John N. Sims, Sr. MARIANNA: James T. Cook, Jr., Courtland D. Whitaker. MELBOURNE: Oswald A. Holzer, Theodore J. Kaminski, Isabel Roberts, Arthur C. Tedford.

MIAMI: Lassar Alexander, Ralph F. Allen, Walter L. Alspach, James L. Anderson, Edward R. Annis, Samuel Aronovitz, William G. Aten, Jr., Stanley H. Axelrod, Hubert A. Barge, William J. Barge, Ernest R. Barnett, Harry E. Beller, George F. Bicknell, Morris H. Blau, Arthur E. Boles, Andrew G. Brown, Earlsworth C. Brunner, John E. Burch, Bruce D. Carroll, Silas E. Chambers, John G. Chesney, Reuben B. Chrisman, Jr., Isaac B. Cippes, Marcus B. Cirlin, George D. Conger, Maurice P. Cooper, Vincent P. Corso, Edward W. Cullipher, DeWitt C. Daughtry, David Davidson, Carl H. Davis, H. Clinton Davis, John E. Dees, Robert F. Dickey, Percy L. Dodge, L. Washington Dowlen, Otto S. Dowlen, Carl E. Dunaway, John G. DuPuis, Wm. H. Ellis, Raymond L. Evans, Frederick E. Farrer, Willard L. Fitzgerald, Emmett T. Fitzpatrick, Marvin G. Flannery, M. Eugene Flipse, M. Jay Flipse, Forrest H. Foreman, Tom R. Gammage, Edmond Gamse, Hollis F. Garrard, Francis W. Glenn, J. Raymond Graves, Maurice M. Greenfield, James J. Griffitts, Dale L. Groom, Howard H. Groskloss, Young L. Hall, Jr., James C. Hardman, Robert M. Harris, Winston F. Harrison, W. Tracy Haverfield, Maurice E. Heck, Ella M. Hediger, Bruce M. Hogg, James W. Holmes, William M. Howdon, William H. Izlar, Ralph W. Jack, Joseph T. Jana, Jr., James K. Johnson, (Col.), Samuel H. Johnson, (Col.), Walter C. Jones, Harold S. Kaufman, Christian Keedy, Jack Keefe, III, Theodore C. Keller, Ralph E. Kirsch, David Kirsh, Morris E. Kuckku, Alexander Kushner, William T. Lanier, George W. Lawson, Robert M. Lee, Rothwell Lefholz, Louis Lemberg, Alfred G. Levin, Nathaniel M. Levin, Simon M. Lipton, George Lister, William D. Lithgow, A. Buist Litterer, Joseph Lomax, Robert O. Lyell, John J. McAndrew, E. Norton McKenzie, Jack A. McKenzie, Norman W. McLeod, Jr., Martin P. Mahrer, Plumer J. Manson, Stanley Margoshes, Donald F. Marion, Isidore Marx, John H. Mason, Jr., Lawrence R. Medoff, James H. Mendel, Sr., Claude G. Mentzer, Hyman Merlin, Robert F. Mikell, John D. Milton, Leon H. Mims, Jr., Harry M. Moore, C. Russell Morgan, Jr., Leo L. Nastasi, Elwin G. Neal, Frank O. Nichols, Wesley S. Nock, Russell K. Nuzum, Jr., Benjamin G. Oren, Morris Ovitz, Bascom H. Palmer, Frazier J. Payton, Colquitt Pearson, Homer L. Pearson, Jr., Nelson T. Pearson, Max Pepper, Irwin Perlmutter, Kenneth Phillips, Roland F. Phillips, Robert C. Piper, Edwin P. Preston, Joseph O. Priestley, Gerard Raap, John R. Ramey, Harold Rand, Jack O. W. Rash, Homer A. Reese, W. Carlton Rentz, Jr., Philipp R. Rezek, Maurice Rich, John R. Richardson, Julian A. Rickles, Samuel J. Roberts, Reuben Rochkind, Hunter B. Rogers, Ruth W. Rumsey, Lyle W. Russell, Walter W. Sackett, Jr., S. Marion Salley, Wiley M. Sams, Ralph S. Sappenfield, Milton S. Saslaw, Chaffee A. Scarborough, Oden A. Schaeffer, George F. Schmitt, Jr., Manuel A. Schofman, Joseph W. Scott, C. Kirby Smith, Donald W. Smith, Parke G. Smith, John W. Snyder, William Steinman, Joseph S. Stewart, Richard F. Stover, William M. Straight, Richard E. Strain, Edwin C. Thomas, Kelly C. Thomas, Henry L. Tippins, John C. Turner, Isaac N. Weinkle, Robert C. Welsh, Lynn W. Whelchel, Kenneth S. Whitmer, William Wickman, Edward H. Williams, George Williams, Jr., Louis J. Wisch, Arthur W. Wood, Jr., Frank M. Woods, Leo S. Wool, Jack L. Wright, Corren P. Youmans, Iva C. Youmans, Leo. A. Zuckerman.

MIAMI BEACH: Mortimer D. Abrashkin, Lester I. Berk, Herman Boughton, Turner E. Cato, Max Dobrin, Rudolph E. Drosd, Maurice I. Edelman, Howard A. Engle, I. Leo Fishbein, Richard M. Fleming, Stanley Frehling, Elias Freidus, Meyer J. Glick, Milton S. Goldman, Max Gratz, Robert J. Grayson, Irvin M. Greene, Leo Grossman, Abraham R. Hollender, Walter T. Hotchkiss, Emil M. Isberg, Valentine E. Jenkins, Lewis L. Julien, Saul H. Kaplan, Samuel B. Kleinman, Maurice Kovnat, Frederick LeDrew, George N. Leonard, Leo M. Levin, Alexander Libow, Charles Lippow, Louis G. Lytton, Saul Miller, Morton B. Morgan, Abraham Nemser, Cayetano Panettiere, S. Joseph Pearlman, Jean J. Perdue, Joseph B. Pomerance, Robert J. Poppiti, Francis A. Reed, Alexander E. Rosenberg, Sol Selevan, Charles Stein, John H. Tanous, Earl R. Templeton, Efton J. Thomas, Rene A. Torrado, M. P. Travers, Harold D. Van Schaick, Harrison A. Walker, Leonard L. Weil, D. Ward White, Charles B. Wigderson, Nelson Zivitz.

MIAMI SHORES: William C. Hutchison, Robert A. Mayer. MIAMI SPRINGS: Laurin L. Andrews, Estella G. Norman, Clyde T. Thompson. MONTICELLO: William L. Hunter. NAPLES: James A. Craig, John J. Meli, Ethel H. Trygstad, Reidar Trygstad. NEW SMYRNA BEACH: James F. Roberston. NORTH MIAMI: Archie McCallister, Jr., Ludwig M. Ungaro, Charlotte K. Wilkins. NORTH MIAMI BEACH: Raymond W. Healy.

OCALA: William H. Anderson, Jr., Harry M. Edwards, Henry L. Harrell, Carl S. Lytle, John N. Moore, Eugene G. Peek, Jr., William H. Turnley. OKEECHOBEE: Leon S. Eisenman. ORLANDO: Clarence Bernstein, Rex M. Bleakney, Dorothy D. Brame, Thomas C. Butt, J. Rocher Chappell, Chas. J. Collins, Russell L. Counts, Leland H. Dame, Horace A. Day, James G. Economon, George W. Edwards, II, Elwyn Evans, L. Paul Foster, Truett H. Frazier, Roger W. Gridley, George W. Griffin, G. Tayloe Gwathmey, Joseph L. Hundley, Eugene L. Jewett, Eldridge W. Johnson, Harold W. Johnson, William H. Kelley, Lawrence H. Kingsbury, Solomon D. Klotz, Morris H. R. Lukens, Newton C. McCollough, Duncan T. McEwan, John S. McEwan, Carl S. McLemore, Charlotte C. Maguire, Meredith Mallory, Sr., T. William Martin, Fred Mathers, William S. Mitchell, George M. Murphy, Robert G. Neill, Louis M. Orr, II, Roger E. Phillips, Isidore Pincus, Frank J. Pyle, Don C. Robertson, George P. Schanck, Jr., (Col.), Adelbert F. Schirmer, Lowell S. Selling, Joseph G. Seltzer, Charles R. Sias, Philip F. Simensky, Joseph L. Stecher, Alfred S. Stevenson, Sam N. Sulman, Leroy M. Sutter, Robert L. Tolle, Richard H. Walker, Jr., Merrill Wattles, Breckenridge W. Wing, Robert W. Young.

PAHOKEE: Chas. E. Creel, Ernest C. Johnson, Jr. PALATKA: Lawrence G. Hebel. PALM BEACH: Joseph Feldman, Alfred F. Henderson, Oscar L. Kelley, Fred E. Manulis, Alvin E. Murphy, David A. Newman, Herman G. Rose, Bailey B. Sory, Jr., Joseph R. West. PANAMA CITY: William C. Roberts. PENSACOLA: Constantine A. Asters, Herbert L. Bryans, Edward G. Byrne, Luther C. Fisher, Jr., William P. Hixon, George W. Morse, Walter C. Payne, Joseph L. Rubel, Alvin L. Stebbins, Frank E. Tugwell, Dale E. York.

PERRY: Mark E. Adams. PLANT CITY: Frank Chambers, Jr., Madison R. Pope. POMPANO BEACH: George S. McClellan. PORT ST. JOE: Albert L. Ward. QUINCY: Taylor W. Griffin. RIVIERA BEACH: Frank M. Hewson, Jr., Robert Y. Wheelihan. ST. AUGUSTINE: Reddin Britt, Joseph A. Shelley, A. Clark Walkup. ST. CLOUD: James C. Rinaman.

ST. PETERSBURG: Arnold S. Anderson, Bernard T. Bell, John R. Butter, Edward L. Cole, Jr., Charles K. Donegan, Ira C. Evans, Loenard Freed, George O. Gundersen, George F. Hieber, Robert M. Kilmark, Frederick C. Knight, Norval M. Marr, Alvin L. Mills, Orville N. Nelson, Harrison G. Palmer, H. Milton Rogers, Franklin W. Roush, Jr., Richard H. Sinden, Benjamin H. Sullivan, Rowland E. Wood. SANFORD: Orville L. Barks, J. Clifford Boyce, John M. Morgan.

SARASOTA: John M. Butcher, Frederick D. Droege, Andrew J. Jesacher, Harold T. Lawler, A. Lamar Matthews, Henry G. Morton, Sherrel D. Patton, Hugh G. Reaves, William A. Shannon, Melvin M. Simmons, Henry J. Vomacka, Millard B. White, Reaves A. Wilson, Thomas R. Young, Jr. SEBRING: Leldon W. Martin, Stanley K. Wallace. SOUTH MIAMI: James H. Mendel, Jr. STUART: Walter F. Davey, Julian D. Parker. TALLAHASSEE: Edson J. Andrews, Merritt R. Clements, Paul J. Coughlin, Ernest W. Ekermeyer, Arthur J. Henry, Jr., Francis T. Holland, Charles F. James, Jr., Odis G. Kendrick, Sr., Clarence W. Ketchum, George S. Palmer, James H. Pound, Henry L. Smith, Jr.

TAMPA: Chadbourne A. Andrews, Efrain C. Azmitia, Richard A. Bagby, Chas. W. Bartlett, William C. Blake, C. MacKenzie Brown, Harold O. Brown, Joseph N. Cabanzo, Leffie M. Carlton, Jr., Harold Carron, Edward F. Carter, Sr., Frank V. Chappell, C. Frank Chunn, Herschel G. Cole, R. Renfro Duke, Joseph C. Flynn, Sherman B. Forbes, Chas. McC. Gray, H. Phillip Hampton, Linus W. Hewit, Samuel G. Hibbs, Wm. J. Lancaster, Frank H. Lindeman, Jr., Frank T. Linz, Herbert B. Lott, Blackburn W. Lowry, Paul J. McCloskey, Myron L. McEachern, Alfonso F. Massaro, Eugene B. Maxwell, Joseph A. Minardi, David R. Murphey, Jr., Robert G. Nelson, Harold G. Nix, Hugh E. Parsons, Julien C. Pate, Sr., Julien C. Pate, Jr., James N. Patterson, William M. Rowlett, James M. San, Roy F. Saxon, Jr., Hawley H. Seiler, Edward F. Shaver, Lynwood B. Smith, Marshall E. Smith, Mason C. Smith, Philip L. Smoak, Wray D. Storey, Harold Sutker, Joseph W. Taylor, Sr., Joseph W. Taylor, Jr., Mason Trupp, Augustine S. Weekley, Frances C. Wilson, Wesley W. Wilson.

TAVARES: James R. Hanson. VENICE: Samuel E. Kaplan. VERO BEACH: James C. Robertson. WEST PALM BEACH: Willard F. Ande, James R. Anderson, Carl E. Andrews, Robert V. Artola, Horace D. Atkinson, John M. Baber, R. Henry Baldwin, Harry E. Bierley, William E. Bippus, Clarence L. Brumback, John F. Chapman, Thomas E. Daly, Joseph J. Daversa, Matthew N. DePasquale, Gerald M. DeWoody, John H. Dyett, (Col.), W. Wellington George, Richard S. Gill, Charles McD. Harris, Jr., Lorenzo James, Jr., V. Marklin Johnson, Oliver L. Jones, R. Gaylord Lewis, W. Ambrose McGee, David W. Martin, Lloyd J. Netto, Harry A. Nevel, Walter R. Newbern, Theodore Norley, Ralph M. Overstreet, Jr., Cecil M. Peek, Atwell B. Pride, (Col.), Raymond S. Roy, Laughlin M. Rozier, W. Lawson Shackelford, Murray D. Sigman, James R. Sory, Edgar W. Stephens, Jr.

WINTER GARDEN: Albert H. Gleason. WINTER HAVEN: Richard D. Field, Ivan W. Gessler, Robert J. Jahn, H. Frederick Keiber, William T. Steele. WINTER PARK: George R. Crisler, Ruth S. Jewett, Walter B. Johnston, Albert C. Kirk, Sr., William L. Musser, Russell W. Ramsey, Henry J. Wiser. ZEPHYRHILLS: Harry G. Brownlee.

Visiting Doctors

BARTOW: A. Hardy Ulm. BOYNTON BEACH: Charles D. Akes. CLEARWATER: James B. Leonard. CLERMONT: William K. Smith. COCONUT GROVE: John F. Aubrey. CORAL GABLES: Robert Blieden, John A. Broward, George P. Cheney, Edward T. Gary, Aron N. Gillman, B. K. Guerin, W. Byrd Hunter, C. S. Janis, Charles A. Langdale, William P. McCarthy, Virgil H. Moon, Jack Reiss, John M. Rumball, Burnett Schaff, J. L. Wolford, Warren Zundell.

FORT LAUDERDALE: Bernhard T. Alm, Donald J. Cady, Elmer R. Conrad, Ella M. A. Enlows, William H. Kirkley, Richard D. Owen, Charles F. Seymour, Calvin H. Shirley, (Col.), Robert G. Talley, Alvin J. Tight. FORT PIERCE: Alfred J. Cornille, Roger E. Hubbard. HIALEAH: Elizabeth Lovejoy. HOLLYWOOD: Billy Jack Bass, Henry Blum, Andre S. Capi, Jerome J. Coffey, Simon D. Ehrlich, Anthony C. Galluccio, Samuel J. Hodkin, Herman Levison, John H. Mickley, William J. Ramel, Jacob A. Rosof, Herbert J. Simon, Israel Spiers, Samuel Tilles, Norman N. Wrubel.

JACKSONVILLE: Thomas B. Christian, Charles H. Gilliland, R. W. McComas, John B. Ross, J. M. Sadler. LAKE BUTLER: Eric F. Geiger. LAKE CITY: Robert M. Alexander, Lino J. Arduino. LAKE WORTH: Arthur T. Rask. MIAMI: James E. Ayre, Thomas J. Baker, Martin Bernstein, Robert J. Bower, David N. Burns, George J. Caruso, MacDonald Caza, Francis N. Cooke, Morris Dressler, Claude G. Eccles, Lee W. Elgin, Jr., Michael M. Gilbert, George Gittelson, Thomas S. Gowin, Daniel O. Hammond, Henry C. Hardin, Jr., Milton J. Hoffman, Albert M. Hyde, Norman S. Jaffe, Max M. Kulvin, Matthew A. Larkin, Bernard Levatin, Richard S. Lewis, Taylor Lewis, Warren Lindau, Louis R. McCallister, Max Millard, Jerry Newman, George M. Nipe, Philip Oransky, C. W. Ringwold, G. Thomas Samartino, Mario Scandiffio, Daniel D. Schlapik, Alvin M. Setz, Calvin M. Steussy, Walter M. White, Jr., John E. Williams, A. L. Wincor.

MIAMI BEACH: Leo Daigneault, Samuel A. Gluck, C. J. Golinvaux, Jerome Greenblatt, Karen Howard, Joseph W. Ketzky, Donald A. Kullman, Harry Permesly, Morris F. Wiener, Daniel Zimmerman. NORTH MIAMI: Ralph J. Haws, Abraham B. Pemsler. ORLANDO: Thomas D. Cook, Julia Edwards, Robert T. Rengarts, Loleta E. Simpson. POMPANO: James A. Pickering. PUNTA GORDA: Frank C. Waltz. ST. PETERSBURG: August E. Gehrke. SARASOTA: Alfred S. Giordano. SURFSIDE: Samuel A. Gunn, Samuel N. Tippett. TALLAHASSEE: J. Paul Chapin. TAMPA: Harry A. Caplan, Marvin L. Cullen, Maurice Haddad, Wm. Mahon Myers, Alan J. Stevenson, Henry C. Sweany, Albert A. Wilson, Robert W. Withers.

VERO BEACH: John T. Perry. WEST PALM BEACH: Hugh Dortch, Jr., Ivan C. Schmidt, Ronald Mack Thompson, Robert J. Trope. WINTER GARDEN: Jack C. W. Warnock.

ALABAMA — SELMA: R. Nelson Long. COLORADO — DENVER: C. Robert Swenson, John Zarit. CONNECTICUT — BRIDGEPORT: Irving J. Sherman. DERBY: Erwin D. Lencz. NEW HAVEN: William J. German. WATERBURY: Charles Henry Audet. WESTPORT: Homer Shoup. DELAWARE — WILMINGTON: Alfred R. Shands, Jr., A. J. Strikol, Leslie W. Whitney. WASHINGTON, D. C.: Paul Eanet, Goldsborough F. McGinnes, Marshall C. Sanford. GEORGIA — ATLANTA: S. Olansky, John M. Whitney. AUGUSTA: Rufus Payne, Peter B. Wright. PELHAM: Edwin M. Walker. SAVANNAH: Samuel F. Rosen. SYLVANIA: Gerald B. Hogsette. VALDOSTA: Joyce F. Mixson, Jr. WAYCROSS: Neal F. Yeomans. ILLINOIS — CHICAGO: Carlo A. Fioretti, S. L. Governale, Frank C. Lawler, Richard H. Lawler, Elmer E. Swanson. CENTRALIA: Harry E. Ryan. PARK RIDGE: Lambert F. Mammoser. INDIANA — FORT WAYNE: Donald S. Painter. HAMMOND: A. C. Remich. JEFFERSONVILLE: John H. Baldwin. RICHMOND: Paul W. Blossom. SOUTH BEND: Alice Giordano. IOWA — DUBUQUE: Paul J. Laube. KENTUCKY — CALHOUN: W. Gerald Edds. LOUISVILLE: William C. Bushmeyer, Kerwin A. Fischer, Paul Mapother. RUSSELLVILLE: John P. Glenn. SPRINGFIELD: Marcus Allen Coyle.

LOUISIANA — NEW ORLEANS: Guy A. Caldwell, Clifford G. Grulee, Jr., A. Seldon Mann. MARYLAND — HAGERSTOWN: Arthur Baptisti, Jr. MASSACHUSETTS — BOSTON: Henry C. Marble. NORTH ATTLEBORO: James A. Bryer, Jr. MICHIGAN — ADRIAN: Carl A. Benz, Charles H. Heffron. DEARBORN: William A. Bailey, Alexander P. Markey. DETROIT: Eugene T. Capuzza, Chester A. Doty, Mary Margaret Frazer, Frank Witter, Nelson J. Young. EAST LANSING: C. Ray McCorvie. GRAND RAPIDS: Carl F. List. KALAMAZOO: Edward R. Nell. NILES: Noel J. Hershey. ORTONVILLE: Milton J. Uloth. PORT HURON: Arthur H. Ulmer. MINNESOTA — ROCHESTER: Joseph H. Pratt. ST. PAUL: Richard O. Leavenworth. MISSOURI — INDEPENDENCE: William H. Hickerson. ST. LOUIS: Joseph E. Von Kaenel. SPRINGFIELD: Harold H. Lurie. NEBRASKA — LINCOLN:

N. Richard Miller. NEW JERSEY — BOONTON: C. A. Musetto. PLAINFIELD: Austin J. Tidaback. PATERSON: A. John Reinhorn.

NEW YORK — BROOKLYN: Harry J. Greene, H. U. Solovay. BUFFALO: Wilfred W. Fuge. MONTICELLO: Stanley A. Kornblum. NEW ROCHELLE: William S. Everts. NEW YORK CITY: George F. Cahill, I. S. Cooper, Abraham Kaplan, Henry F. Kramer, Jr., L. A. Salmon, Joseph Schandorf, (Col.), Joseph Siris. PELHAM MANOR: Margaret Bashford. ROCHESTER: Philip M. Winslow. NORTH CAROLINA — CONCORD: James Walter Brown, Jr. DURHAM: James Hubert Davidson. OHIO — CINCINNATI: Lawrence J. Gibboney, Chapin Hawley, Donald L. Jacobs. CLEVELAND: Charles W. Elkins, Julius Wolkin. COLUMBUS: Reuben B. Hoover. DAYTON: David L. Bernie, Rudolph H. Caplan. LANCASTER: Victor N. Kistler. MANTUA: Edgar A. Knowlton. MIDDLETOWN: Walter A. Reese. WARREN: Alfred Fillmore Compton. YOUNGSTOWN: Edwin R. Brody. PENNSYLVANIA — PHILADELPHIA: Seymour Martin Albert. Thomas B. Mervine, Leslie Nicholas, James S. Shipman, M. William Yarrow. HAVERFORD: James I. Hykes. LANCASTER: Harold K. Hogg. PITTSBURGH: George E. Crum. READING: Paul C. Craig. SOUTH CAROLINA — ORANGEBURG: Orin R. Yost. TENNESSEE — KNOXVILLE: John H. Lesher. LAWRENCEBURG: Laurence B. Molloy. MEMPHIS: Robert S. Harris, Jr. NASHVILLE: Ray O. Fessey. OAK RIDGE: Marshall Brucer. WEST VIRGINIA — BLUEFIELD: Charles M. Scott. FAIRMONT: S. W. Parks. WISCONSIN — ASHLAND: C. J. Smiles. GREEN BAY: J. E. Levitas. MADISON: R. M. Wheeler. MILWAUKEE: Ben L. Fabric, Norvan F. Gordon, Sidney P. Hurwitz. PLATTEVILLE: George Willard Bair.

CANADA — TORONTO: Mark Creaghan, Robert A. Dicker. COSTA RICA: J. L. Orlich. ENGLAND — LONDON: John McMichael, Joseph H. Rayner. SPAIN — MADRID: Mariano Perez Martinez.

Other Guests

HOLLYWOOD: Mr. Sidney Holland. JACKSONVILLE: Mrs. Alfred I. duPont, Mr. Ernest R. Gibson, Mr. Thomas R. Jarvis, Mrs. Zoe Z. Pack, Mr. W. Harold Parham, Mr. H. A. Schroder. Mr. and Mrs. Thomas B. Slade. MIAMI: Mrs. Arthur E. Curtis, Mr. John C. Lee, Colonel Oscar N. Taylor. MIAMI BEACH: Mr. Samuel Gertner. WEST PALM BEACH: Mr. and Mrs. Henry K. Herpel. WASHINGTON, D. C.: Mr. James W. Foristel. ILLINOIS — CHICAGO: Mr. Alfred J. Jackson.

Annual Joint Report of Secretary-Treasurer, Samuel M. Day, M.D. Managing Director, Stewart G. Thompson, D.P.H.

Membership

The membership on March 20, 1953 when the Association's books were closed for auditing totaled 2,415. A year ago, the total was 2,285. These figures are current and not on a calendar year basis.

The following members are not required to pay dues: life, 109; honorary, 81; dues excused, 27; military, 37; and secretaries of county medical societies, 35, making a total of 289 members who are not required to pay state dues.

The six county medical societies having a total membership of more than one hundred are Dade 625, Duval 255, Pinellas 197, Hillsborough 178, Orange 164 and Palm Beach 121.

The above is based on the fiscal year ending March 20, 1953 and is not comparable on a calendar year basis. A number of members who have not yet paid 1953 dues will be dropped from the Association's membership roster after December 31 for failure to pay dues during the calendar year. Also, some of those now listed as members will be subtracted from the current membership total in case of death or moving from the state. Another factor affecting the difference between the fiscal year total membership and the calendar year will be new members coming in after the books were closed for the fiscal year on March 20, 1953.

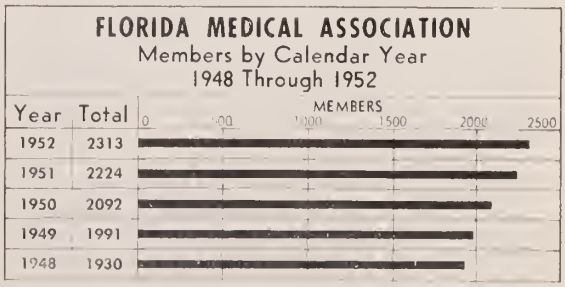
Beginning with 1948, a record of the combined regular and honorary membership by calendar years has been tabulated. The chart which follows shows this record 1948 through 1952. It will be noted that the membership has steadily increased during the 5-year period.

Florida Association Dues

At the beginning of each calendar year, a roster of membership for each county medical society is prepared in duplicate. One copy is sent to the secretary of the county medical society and the other copy is kept in the Association's office. With the copy going to the secretary of the county medical society are instructions concerning the details for collecting state dues. No individual member is permitted to send dues direct to the state office. They must clear through his county medical society.

In addition to the typed copy of the county society roster, an individual card is maintained in the office on each member showing the number of years he has paid state dues. The maintaining of this ready reference and checking the reports and remittances for dues from the 36 county medical societies creates a continuous flow of incoming mail throughout the year. The majority of the county medical societies elect a new secretary-treasurer each year, therefore, there is a volume of correspondence to keep the membership records in agreement between the individual member, the county society record and the state office record.

In order that a member may not be delinquent in paying his state dues, two notices are sent to him during the year. Copy of each notice is sent to the secretary of his county medical society. This is important to the individual. If he fails to pay his state dues through his county medical society before December 31 of the current calendar year, his name is dropped from the membership roster of the Association.



F.M.A. House of Delegates

It is necessary, according to the By-Laws, to have an authentic membership record for the calendar year as the dues are paid on that basis and the county medical societies need the official total on their membership as they are entitled to one delegate to the House of Delegates for each 20 regular members or major fraction thereof at the end of the calendar year. Official information is transmitted to the secretaries of the various county medical societies. The state total, as well as the total for each county medical society for the preceding calendar year, is published in the following February Journal. Honorary members are not entitled to vote, therefore, the membership on which is based the number of delegates from the local society does not include the total of honorary members. The published figures in the February Journal are run in two columns, regular members and honorary members.

A.M.A. Dues

The secretaries of our county medical societies collect A.M.A. dues and forward the reports to the Association's office in Jacksonville. This gives an opportunity to verify each remittance against the membership records, as a doctor is not permitted to belong to the A.M.A. unless he is a member of his state association. On the A.M.A. dues, the secretary of the county medical society encloses checks made payable to the A.M.A. and your executive office forwards these remittances to the A.M.A. This is an important procedure. This involves approximately $50,000 a year, and of course, is not an income for the state Association and, therefore, cannot be deposited in a local bank or become a part of our Association's income and disbursements. This places a heavy load of detail work on our office staff and county medical society secretaries but seems to be necessary as it would be almost impossible for the A.M.A. to collect dues of their individual members, since they would have no record of the doctors who are members of a state association which would be kept current enough to determine when a member dropped out of a state association or died or moved to some other state. This current information would have to be up-to-date for the A.M.A. to use consistently. A roster of A.M.A. members is prepared in duplicate each year, one copy retained in this office and the other given to the county society secretary. This system is similar to that used for members of the state Association.

A.M.A. House of Delegates

The A.M.A. By-Laws read in part:

"The appointment of delegates from each constituent association shall be one delegate for each thousand (1,000) or fraction thereof active members of the A.M.A. as recorded in the office of the Secretary of the A.M.A. on December 31 of each year. Such apportionment shall take effect the ensuing January 1 and shall remain effective for one year thereafter. In January of each year, the Secretary of the A.M.A. shall notify each constituent association of the number of delegates to which it is entitled during the current year."

This By-Law of the A.M.A. is not understood by all of our members. The number of our delegates to the A.M.A. is based on membership records as compiled in the A.M.A. office and not the number of members of the Florida Medical Association. On December 31, 1952, there were 1,983 members of the Florida Medical Association enrolled as active members of the American Medical Association which entitles us to two (2) delegates to the A.M.A. for the calendar year 1953. If 18 more of our members had paid the $25 A.M.A. dues last year, we would have had three (3) delegates this year.

The Journal

The number of journals printed during the past fiscal year totaled 31,991, as compared with 30,746 for the previous year — an increase of 1,245.

All scientific articles are approved by the Committee on Publication including the Editor of The Journal. All material published in The Journal is processed in the office before going to the printer. When the galley proofs are returned to the office, they are read against the original copy. A dummy journal is paged for proper arrangement in the different sections which includes the arranging of the advertising pages. When the page proof from this dummy is received from the printer, it is again re-checked before the journals are run off the press.

The journals are then delivered to the office, run through the Addressograph machine, sacked, and taken to the Post Office by truck. It requires 15 large mail bags to sack the journals. In order to obtain the pound rate on postage, the journals must be bundled, labeled and tied for the various postal zones throughout the state and country.

Medical Directory

The first issue of your Florida Medical Directory was published in 1938 and has been issued each year thereafter. One free copy of the 1953 Directory was mailed to each member of the Association, continuing the precedent set with the first publication. The value of this Directory is noted by the increasing sale of extra copies at $2.00 each. It contains a complete roster by county medical societies, giving the name and local address of each member. Roster 2 is an alphabetical list of licensed medical doctors residing in Florida. Roster 3 gives the names and cities of non-resident Florida-licensed medical doctors. A record of doctors newly licensed in Florida is submitted by the Secretary of the State Board of Medical Examiners; each year, approximately 400 names of newly licensed doctors are received through this splendid cooperation. In addition, the following are included: members of the State Board of Medical Examiners, Board of Basic Science Examiners, State Board of Health, Blue Cross, Inc., Blue Shield, Inc., Hospital Advisory Council, Florida Hospitals, Florida Blood Banks, Medical Laws, etc.

The Directory is compiled as of October in order to be mailed the following January. The master membership records are the basis for doctors' names to be published. Members' names are published in capital letters and doctors licensed to practice medicine in Florida but who are not members are published in lower case. It is a voluminous task to prepare the copy for this Directory before it is sent to the printer, and the work in the office is timed for October to clean it up before the late fall and the New Year's rush. The galleys from the printer on 70 pages of fine print must be proofread in the office and a printer's dummy prepared, which requires 2 staff members, one to read original copy and the other to check the galley proofs. To compile this year's Directory, beginning last October, it was necessary to work from steel card stacks on over 4,000 individual card records. The actual printing cost is largely covered by advertisements in the Directory. It is obvious, however, that the major cost comes under the heading of office staff. The increase in demands for these Directories more than justifies the cost involved, however.

Exhibits

The value of technical exhibits as a medium between the doctors and firms displaying products and equipment is emphasized by the increase in the number of firms exhibiting at the Association's Annual Conventions. At the 1953 meeting, the exhibit room, 145 ft. by 90 ft., was completely filled and it was necessary to move the scientific exhibits to another location. The income through April from these exhibits which were on display for 3½ days amounted to well over $13,000. Care has been taken not to have the rental price too high and as a result, the same exhibitors return to the conventions year after year. Representatives of exhibiting firms from coast

to coast are in attendance and are unusually cooperative. It is surprising how many of these representatives visit the Association's Executive Office during the year.

The scientific exhibit hall is growing larger and larger. At the 1953 meeting in Hollywood, the Arcade on the ground floor housed the scientific exhibits and although arrangements were made to provide for all repeaters, so many applications were received after the floor plan was completed, that a few could not be accepted. These booths are 8 ft. wide and 4 ft. deep with panel backs 7 ft. high, the side panel dividers extended 4 ft. The cost of erecting these scientific booths is $25 each. The Association bears this expense since the exhibits are scientific and not for profit.

Briefs

This is the Association's newsletter to members. It is processed when information should go to the members promptly, since The Journal is only mailed once each month and it is necessary to have an extra month to get ready and mail The Journal. "Briefs" to the entire membership may be gotten out in about two days. "Briefs" are reproduced by the Mimeograph, envelopes run on the Addressograph, contents folded and stuffed, ready for sealing and stamping on the Postage Meter. "Briefs" just to county medical societies and short lists are run more quickly.

It would be helpful if our members would give their impression of this phase of the work. Are you receiving the information desired through this newsletter? Any constructive criticism that will improve or make the "Briefs" more useful will be gratefully received.

Mimeographed Roster of Certain Committees

Once each year, a roster is mimeographed of the State Association and County Medical Society Committees on Public Relations, Legislation, Grievance, Advisory to Selective Service, Emergency Medical Service and Committees to Urge Gifts to American Medical Education Foundation.

The names of the Florida Medical Association Committees and the committees from each of the county medical societies are mimeographed, bound, and mailed to each individual whose name is listed. To obtain the names of the county society individuals, a questionnaire is sent out to the secretary of each county medical society and the replies included in the publication. This is somewhat of a task, but has proven to be of considerable value throughout the state.

Labor-Saving Machines

The Graphotype is a machine on which Addressograph plates are made. The metal plates are 1-3/4" x 4", and the member's complete address is cut in the plate by this embossing process. Each letter of the alphabet and numbers are on individual dies. When a letter or figure is broken or wears out, a new die may be inserted. When embossing a plate, the operator may space between characters, or back space as desired. After the plate is completed, there is a roller that goes over it to smooth out indentures and the plate itself. By the use of this machine, a tremendous amount of time is saved over the old methods of typing or writing addresses on mailing lists of various lengths.

The Addressograph. On this machine which is electrically operated, envelopes are addressed for letters going to the entire membership, secretaries and/or presidents of county medical societies, the newsletter known as "Briefs," Journals each month, Directories, etc. The Addressograph plates are arranged for running off various lengths of lists. When The Journal is being addressed, the impression from the plate is put on the cover, which saves the expense of purchasing and imprinting special envelopes. The membership lists of plates are kept currently up-to-date. When a member changes his address, the old plate is taken out and a new one substituted in its place. This is very important as there is no delay when getting out The Journal or any other list. By the use of the Addressograph, The Journal, comprising more than 2,400 copies each month, is addressed ready for mailing in less than one day. The addressing of envelopes for "Briefs" going to all members of the Association is also completed in less than one day. Without this Addressograph, a much larger office staff would be required.

Postage Meter. This machine also lessens the number of staff members needed in the office. When letters are ready for mailing, this Postage Meter seals and stamps them automatically. This is a wonderful saving over the old two-operation method of sealing each envelope and placing a stamp on the other side. It is also advantageous in a large office, as it is not necessary to have postage stamps in stock and there is another protection — that all envelopes must have the Association's name and address imprinted on the outside, so the postage cannot be used for personal letters. Some years ago, we had a sad experience during hot, damp weather when rolls of postage stamps stuck together. They were housed in a steel cabinet, so there was a question as to whether the trouble was caused at the post office when the stamps were purchased or after having been received at the office. Fortunately, the post office cooperated to see that the Association had no loss as a result of the damage. There will be no such experience in the future. Another saving worth mentioning: the Postage Meter is taken to the post office with the Association's check and the credit is posted. This is only necessary occasionally, which saves the troublesome and tedious purchasing, housing and handling of various denominations of stamps.

Bureau of Public Relations

This Bureau is within and a part of the Association's Executive Office. The Supervisor and his assistant visit the chairmen of the county medical societies' committees on Public Relations to aid in the initial setting up of local programs. This does not, however, imply that the representative will do the actual processing of local activities, as that would be impossible with the limited staff for 36 county medical societies.

During the past year, the personnel in the Bureau have been assigned to special duties with the Association's Committee on Public Relations and Legislation and Public Policy. The field work is of primary importance and your office desires to be of all possible help and assistance.

Some of the activities of the Bureau Staff include contacts with the press, radio, television and reputable allied and lay organizations. Health topics on items of medical interests have been supplied regularly throughout the year to weekly newspapers. Transcribed programs on health subjects have been distributed in cooperation with county medical societies for broadcasting by radio stations. Radio and television scripts for live programs are available to all county medical societies on request.

The Association's Fair Exhibit, shown for the first time at the 1952 Florida State Fair in Tampa, has been displayed at the North Florida Fair in Tallahassee and the Central Florida Exposition at Orlando.

The High School Essay Contest was sponsored again this year in cooperation with the county medical societies. Every Junior and Senior High School in the state was supplied with a packaged library kit. Cash awards of $100, $50 and $25 were made by the Association to the state winners. Dr. Jere W. Annis of Lakeland served as Chairman of the Committee of Judges, assisted by Mr. Rogers Whitener and Mr. John D. Byrd, faculty members of Florida Southern College.

Assistance was given in obtaining physicians as speakers at farm organizations as part of the Rural Educational Program. Literature and health posters were provided to county and home demonstration agents for distribution to farmers and their wives.

The Bureau's Supervisor, W. Harold Parham, returned from a tour of Far Eastern duty in the Army last October.

Office Staff

In your Executive Office in Jacksonville, there are 10 full-time members of the staff: Stewart Thompson, Managing Director; Ernest Gibson, Assistant; Harold Parham, PR Supervisor; Tom Jarvis, Assistant; Mrs. Zoe Pack, Chief Clerk; Mrs. Mae Mason, Head Stenographer; Mrs. Florence Barry, Steno-Clerk; Miss Blois Brown, Journal Technician; Miss Ruth Urpila, Records Clerk; Miss Edna Nolan, Clerk-Steno. Special services on contract are: Mrs. Edith Hill, Medical Writer; Mrs. Naomi Hilton, Auditor.

The personnel of your office staff are anxious and willing to serve you to the best of their ability. Some of the services now being rendered may be worthy of comment: assist the Board of Governors by preparing agendas, taking down the proceedings, typing minutes, etc.; assist various regular committees, also the Chairman of the Council in the Medical District Meetings; contracting with printers for programs, Handbooks for Members of the House of Delegates; badges for Annual Meetings; general correspondence, etc.

Programs for annual Specialty Group Meetings held the Sunday before the Association's Annual Meeting are obtained from the officers of the various groups and when completed, have been published in the Convention Number of The Journal and in the printed program given out at the meeting. It is very difficult to obtain this information during the month of January, which is necessary to be published in the March Journal.

We would not attempt to describe the volume of work and schedules that must be followed in your Executive Office. Most of the members are not interested in the details, so we have endeavored to touch the high spots and will be very glad to have any of the members visit the office, where they will be taken on a tour through it and as far as possible answer any questions that may be asked.

Finances

Receipts for the fiscal year ending March 20, 1953 totaled $126,557.51 and the disbursements were $96,728.88. The difference between these two totals must not all be considered surplus. The state dues are payable on a calendar year basis and the fiscal year totals as given in the financial statements here are from Annual Meeting to Annual Meeting for the fiscal year. The major part of the state dues for 1953 has already been received. The expenses for operating until the 1954 Annual Meeting must largely be taken from the balance on hand at this time.

The financial statements appearing at the end of this report are published for the information of our members. The books and records of the Association are open to the members and we will gladly endeavor to answer inquiries of any nature upon request. The books have been audited by Goodrich & Varnadoe, Certified Public Accountants, and a certificate of the audit is incorporated in the statements which follow.

Respectfully submitted,
Samuel M. Day, M.D., *Secretary-Treasurer*
Stewart G. Thompson, D.P.H., *Managing Director*

Dr. Samuel M. Day — April 20, 1953
Secretary-Treasurer
Florida Medical Association
Jacksonville, Florida
Dear Sir:

In compliance with request of Mr. Stewart G. Thompson, Managing Director, Florida Medical Association, we have examined the books of account, vouchers and other records of the Association, maintained in his office, for the period March 21, 1952 to and including March 20, 1953, and submit herewith our report consisting of:

Exhibit "A" — Statement of Assets and Liabilities as at March 20, 1953
Exhibit "B" — Statement of Receipts and Disbursements for period March 21, 1952 to March 20, 1953
Exhibit "C" — Analysis of Changes in Retirement Trust Fund
Exhibit "D" — Statement of Receipts and Disbursements—Medical Postgraduate Course Committee

The recorded receipts were regularly deposited to the credit of the Association, and the disbursements appeared to be for proper purposes.

Bank balances were reconciled with books of account and we inspected war bonds of a maturity value of $40,325.00.

Due to inaccessibility of records of the various County Societies no attempt was made to verify remittances for dues, or the accounts receivable of the association.

Yours very truly,
(Signed) Goodrich & Varnedoe
Certified Public Accountants

CHG/d

Exhibit "A"
Statement of Assets and Liabilities
March 20, 1953

Assets			
Atlantic National Bank—Checking A/c		$56,598.63	
Florida National Bank—Checking A/c		47,583.75	
Atlantic National Bank—Savings A/c		9.17	
Barnett National Bank—Savings A/c		1,940.53	$106,132.08
Accounts Receivable:			
General Fund	$19,880.00		
Journal Fund	1,059.24		20,939.24
Inventory—Stationery			2,975.12
Retirement Trust Fund—Atlantic National Bank			17,216.81
Investments:			
Treasury and Savings Bonds			29,840.50
Furniture & Fixtures:			
General Fund	$9,664.91		
Less Depreciation Reserve	4,190.57	$5,474.34	
Bureau of Public Relations Fund	$3,706.24		
Less Depreciation Reserve	1,139.14	2,567.10	8,041.44
TOTAL ASSETS			$185,145.19
Liabilities			
Net Worth			$185,145.19
TOTAL LIABILITIES AND NET WORTH			$185,145.19

Exhibit "B"
Statement of Receipts and Disbursements
March 21, 1952 Through March 20, 1953

Balances — March 21, 1952		
Atlantic National Bank—Checking A/c	$ 57,206.84	
Florida National Bank—Checking A/c	17,166.16	
Atlantic National Bank—Savings A/c	9.17	
Barnett National Bank—Savings A/c	1,921.28	$ 76,303.45
Receipts		
Back Dues	$25,320.00	
Current Dues	65,160.00	
Entrance Fees	2,250.00	$ 92,730.00
Interest on Savings Accounts		19.25
Miscellaneous Income		680.03
Advertising—Journal	$16,424.23	
" —Directory	720.00	17,144.23
Journal Subscriptions & Sales		334.00
Directory Sales		514.00
Technical Exhibits		12,715.00
Convention Smoker		2,421,00
TOTAL RECEIPTS		126,557.51
TO BE ACCOUNTED FOR		$202,860.96

Disbursements

Administrative:		
Postage and Express	$ 788.87	
Office Supplies	689.45	
Telephone and Telegraph	1,237.25	
Travel Expense — Mng. Dir. and Asst.	892.33	
Delegates to A.M.A. (3) Transportation	984.39	
Office Rent	2,400.00	
Bank Exchange	7.41	
Custody of Bonds	50.00	
Treasurer's Bond	228.60	
Comprehensive & Liability—Auto Insurance—Employees	31.15	
Employer's Liability Insurance	33.62	
Maintenance — Office Equipment	304.37	
Rental—Safety Deposit Box	12.50	
Blue Cross and Blue Shield (Assn. Employees)	172.80	
Federal Tax	627.35	
State Sales Tax	678.40	
Unemployment Compensation Fund	507.85	
Federal Excise Tax	56.97	
Furniture & Fixtures	2,010.20	
Books, Pamphlets, Etc.	314.30	
Payrolls	30,908.66	
Contractor Fees	2,078.22	
Retirement Trust Fund	3,600.00	
Journal Printing and Paper	16,546.52	
Dray	61.80	
Printing and Engraving	1,490.57	
Directory Printing, Etc.	1,690.65	
Convention Expense	2,857.50	
Miscellaneous Committee Expense	747.50	
Convention Smoker, Etc.	2,085.75	
Dues—Conference of Presidents	75.00	
Incidental	25.75	
TOTAL ADMINISTRATIVE		$74,195.73
Bureau of Public Relations:		
Postage and Express	$ 656.69	
Office Supplies	371.64	
Payrolls	9,380.46	
Contractor Fees	62.50	
Insurance Blue Cross and Blue Shield (Assn. Employees)	69.60	
Telephone and Telegraph	486.15	
Travel Expense—Supervisor and Asst.	2,109.89	
Federal Tax	166.97	
State Sales Tax	48.63	
Unemployment Compensation Fund	230.46	
Federal Excise Tax	25.06	
Office Rent	1,272.00	
Books, Pamphlets, Etc.	456.69	
Printing and Engraving	1,355.76	
Maintenance — Office Equipment	37.13	
Legislation, Public Policy	3,000.00	
State Education Campaign	2,632.30	
Incidental	4.35	
Chamber of Commerce Membership	100.00	
Insurance—Projection Equipment (3 Year Policy)	66.87	
TOTAL BUREAU OF PUBLIC RELATIONS		22,533.15
TOTAL DISBURSEMENTS		96,728.88
Balance — March 20, 1953		$106,132.08
Balance Comprised of:		
Atlantic National Bank—Checking A/c	$56,598.63	
Florida National Bank—Checking A/c	47,583.75	
Atlantic National Bank—Savings A/c	9.17	
Barnett National Bank—Savings A/c	1,940.53	$106,132.08

Exhibit "C"

Retirement Trust Fund
Analysis of Changes
March 21, 1952 Through March 20, 1953

BALANCE ON HAND—March 21, 1952		$16,816.81
ADDITIONS		
Transfers from General Fund	$3,600.00	
Income:		
Gross Interest on Bonds	400.00	
NET ADDITIONS		4,000.00
		$20,816.81
DEDUCTIONS		
Distributions to Dr. Stewart G. Thompson 12 Months at $300.00		3,600.00
BALANCE ON HAND—March 20, 1953		$17,216.81

Exhibit "D"

Medical Postgraduate Course Committee—XI
March 21, 1952 Through March 20, 1953

Receipts		
Cash as per Last Audit		$1,826.58
Registration Fees, Etc.—1952 Postgraduate Course		2,160.00
TO BE ACCOUNTED FOR		$3,986.58
Disbursements		
Dr. T. Z. Cason, Chairman—Expenses	$1,000.00	
Department of Medicine—University of Florida	2,986.58	3,986.58
BALANCE IN BANK—March 20, 1953		$ .00

Exhibit "E"
Dues and Entrance Fees Collected March 21, 1952 Through March 20, 1953

Name of Society	Total Numbers	No. Paid Members	No. in Arrears	1953 Dues Collected	Back Dues Collected	Entrance Fees
Alachua	46	41	5	$ 1,320.00	$ 40.00	$ 10.00
Bay	24	19	5	640.00	520.00	10.00
Brevard	25	22	3	720.00	200.00	40.00
Broward	93	80	13	2,840.00	640.00	110.00
Columbia	14	10	4	320.00	160.00	10.00
Dade	625	412	213	14,560.00	9,280.00	540.00
DeSoto-Hardee-Highland-Glades	25	24	1	680.00	80.00	
Duval	255	160	95	4,920.00	4,120.00	180.00
Escambia	88	85	3	2,920.00	800.00	180.00
Franklin-Gulf	7	7	0	200.00	40.00	
Hillsborough	178	143	35	4,960.00	1,680.00	130.00
Indian River	7	6	1	120.00	40.00	
Jackson-Calhoun	19	18	1	560.00	160.00	40.00
Lake	27	24	3	880.00	200.00	10.00
Lee-Charlotte-Collier-Hendry	29	29	0	1,040.00		60.00
Leon-Gadsden-Liberty-Wakulla-Jefferson	59	49	10	1,560.00	2,000.00	80.00
Madison	4	3	1	80.00		10.00
Manatee	19	14	5	440.00	200.00	30.00
Marion	27	17	10	480.00	520.00	20.00
Monroe	15	7	8	160.00	160.00	30.00
Nassau	12	11	1	320.00	80.00	20.00
Orange	164	158	6	5,840.00	1,240.00	220.00
Palm Beach	121	113	8	4,200.00	520.00	50.00
Pasco-Hernando-Citrus	18	18	0	560.00	40.00	30.00
Pinellas	197	186	11	6,400.00	560.00	200.00
Polk	97	84	13	2,840.00	560.00	110.00
Putnam	9	9	0	280.00	80.00	
St. Johns	15	15	0	480.00	40.00	
St. Lucie-Okeechobee-Martin	15	12	3	400.00	280.00	
Sarasota	47	31	16	920.00	280.00	40.00
Seminole	18	18	0	600.00		20.00
Suwannee	8	6	2	120.00	160.00	
Taylor	4	1	3		80.00	
Volusia	82	64	18	2,200.00	520.00	50.00
Walton-Okaloosa	17	17	0	480.00	40.00	10.00
Washington-Holmes	5	5	0	120.00		10.00
Totals	2,415	1,918	497	$65,160.00	$25,320.00	$2,250.00

Dues Not Payable			25,320.00 Back Dues Collected
Co. Soc. Secys.	35		
Life	109		90,480.00 Total Dues Collected
Excused	27		2,250.00 Entrance Fees Collected
Honorary	81		
Military	37		
		289	
Paying Dues		1,629	92,730.00 Dues and Entrance Fees

Report of Editor of The Journal
Dr. Shaler Richardson

The Journal well merits the dignity and respect which comes with age and decades of service. It is now entering its fortieth year. Many cherished traditions have been established and many previously proud records have fallen by the wayside as The Journal has kept pace with the tremendous advances in medical science since the turn of the century.

It has been a treasured privilege to have been associated continuously with this ever growing medical journal since 1925. All but three of those years were in the capacity of Editor. It is gratifying to know that I may have had some small part in this progress. Whatever I may have been able to contribute, it has been insignificant in comparison with the many and varied compensations which inevitably fall to an editor of an outstanding journal.

Reader interest in The Journal has naturally become greater with the steady increase in membership down through the years. Current figures show an average monthly circulation of 2,547. In March, 2,708 Journals were mailed out. Of these, 2,296 went to active members, the remainder were sent to individual subscribers, advertisers and exchanges.

I never fail to be astounded at the number of inquiries and comments received from far-away lands. We have frequent requests for reprints from foreign countries. Requests of this nature in the past year have come from the remotest corners of the world. We have paid subscriptions going to Canada, England, Africa, Germany and Italy. The most recent foreign subscription request came from Australia.

Interest from foreign readers centers on the more highly technical papers, particularly those publishing results of research. In this country those same articles have widespread appeal. But, there are papers which create reader interest outside the medical profession. They are those with wide popular appeal by the very nature of their subject matter. They are no less scientific and frequently involve intensive study and research. They invariably catch the attention of newspapermen and free lance science writers. During the past year papers of this type published in The Journal include those on dermatologic dangers of sunlight and on baby feeding.

Our editorials are outstanding. We admit to being second to no other medical journal in the country in this respect. This success is due to the contributions of the Assistant and Associate Editors. Unique and outstanding are those on medical history. Enchantingly written as well as tastefully and pertinently illustrated, they make Florida men of medicine of the past come alive on the pages of The Journal. These priceless contributions to medicine and history are the work of our talented physician-historian, Dr. Webster Merritt, an Assistant Editor.

At the annual banquet at Hollywood on April 29, 1952, Mr. Virgil E. Newton, Managing Editor of the Tampa Morning Tribune, gave a timely and inspiring talk. His address was published in the September Journal and immediately we began to receive congratulatory messages from all over the country from doctors and laymen alike. It was reprinted in response to a demand for copies. It was reproduced in full in other medical journals.

Publishing costs are the highest in history with no indication of any reduction in the foreseeable future. Paper stock is expensive and difficult to obtain. Due to the many years Stewart Thompson dealt honorably and fairly with paper dealers this is not as yet a serious problem. It has been found advisable to curtail seriously exchanges and complimentary copies.

During the past fiscal year 51 scientific papers were published of which 44 were by members. Seventeen of the papers published, 15 by members and 2 by guest speakers, were read at the 1952 Hollywood meeting; one was read at the 1951 Hollywood meeting. In addition, the Committee on Publication accepted five papers from non-members because these papers were deemed to contain timely scientific information which would benefit the members.

Abstracts provide members with information on scientific subjects. During the past year 42 abstracts of articles published by our members in other journals were published in The Journal. Other journals are scanned by the staff in search of articles written by our members. However, to avoid the missing of some valuable papers, members are urged to send in reprints of their articles published in out-of-state medical journals.

News items and county society notes are of special interest to our members. Some are obtained from a newspaper clipping service and others from county medical society bulletins. Some few societies have reporters whose duty is to make sure that The Journal receives news of the society and its members regularly.

Other features of The Journal include Florida Blue Shield, State Board of Health, Books Received, Correspondence, and the Woman's Auxiliary section. In addition, The Journal carries a list of Association officers and committee members, a schedule of meetings of certain medical organizations and a tabulation of the county societies with their presidents, secretaries, meeting dates and current membership.

I wish to express appreciation not only to the Assistant Editors, Dr. Merritt and Dr. Franz H. Stewart, but also to the Associate Editors, Drs. Louis M. Orr, II, Joseph J. Lowenthal, Jere W. Annis, Herschel G. Cole, Wilson T. Sowder, Carlos P. Lamar, and Walter C. Payne.

The assistance of the two other members of the Committee on Publication, Drs. Chas. J. Collins and James N. Patterson, has been invaluable. One or both of these doctors read and edited the scientific articles published in The Journal before they were finally referred to me. The time and effort given by these men should merit the special appreciation of the entire membership.

Dr. Kenneth A. Morris, abstract chairman, and his assistant, Dr. Walter C. Jones, are responsible for the smooth functioning of the abstract department.

The Journal has been extremely fortunate to have had an outstanding, talented and loyal Managing Editor for more than a quarter century. It was a privilege and an honor to work side by side with him these many years. Together Stewart and I watched the infant publication grow and develop into one of the finest medical journals in the country.

It is obvious that a great amount of detail is essential month after month in the publication of The Journal. We are fortunate to have a competent, efficient lay staff trained under Stewart Thompson. Mr. Ernest Gibson, Assistant Managing Editor, is currently completing his sixth year with the Association; the past four of these he has been directly responsible for much of the detail in preparing each issue of The Journal for printing. He is in turn ably assisted by Miss Blois Brown, Journal Technician. Special mention goes to Mrs. Edith B. Hill, Manuscript Editor and editorial writer. Many Journal authors have had occasion to utilize and appreciate her valuable talent.

The Journal belongs to the members. Its contents are dependent on what you contribute. Send your comments and criticisms; they will be welcomed. The Journal can be the kind of publication the members want only if the members make their desires known.

Respectfully submitted,
Shaler Richardson, *Editor*

Stewart Gordon Thompson
1881--1953

In Memoriam

As the Editors sit down to write a tribute to Dr. Stewart Thompson, they offer a little prayer: Oh, that their thoughts and the words they pen may be highly articulate.

Can it be said that Stewart Thompson is no longer here? We can see the twinkle in his eye. We can hear his voice. We can recall vividly his expression as he talked with quiet dignity and sometimes rather sharp humor, always appropriate and accurately aimed, which usually reached its target and accomplished its purpose. We can form a visual image of Dr. Thompson as he consistently played down his own personality and position while pushing forward officers and members of the Association; he mirrored the reflection of a remarkable man who quietly and efficiently went about the business of helping establish an outstanding Association through devoted service unparalleled in its history.

We know why Dr. Thompson was loved by many men. When men give their love to another man, no higher tribute can be paid him. We know that as the members of the Association carry on, his spirit will still be with them and goal after goal for which he worked unceasingly for twenty-seven years will yet be reached as has many another already been attained.

FLORIDA MEDICAL ASSOCIATION

OFFICERS AND COMMITTEES

OFFICERS

FREDERICK K. HERPEL, M.D., President....*W. Palm Beach*
DUNCAN T. MCEWAN, M.D., Pres.-elect.....*Orlando*
THOMAS H. BATES, M.D., 1st Vice Pres.....*Lake City*
RUSSELL B. CARSON, M.D., 2nd Vice Pres...*Ft. Lauderdale*
THOMAS C. KENASTON, M.D., 3rd Vice Pres.....*Cocoa*
SAMUEL M. DAY, M.D., Sec'y-Treas.....*Jacksonville*
SHALER RICHARDSON, M.D., Editor.....*Jacksonville*

ACTING MANAGING DIRECTOR

ERNEST R. GIBSON.....*Jacksonville*

BOARD OF GOVERNORS*

FREDERICK K. HERPEL, M.D., Chm...(Ex Officio)..*W.P.B.*
EDWARD JELKS, M.D...AL-54.....*Jacksonville*
JAMES H. POUND, M.D...A-54.....*Tallahassee*
NORVAL M. MARR, M.D...C-55.....*St. Petersburg*
JOHN D. MILTON, M.D...D-56.....*Miami*
MEREDITH MALLORY, SR., M.D...B-57.....*Orlando*
DAVID R. MURPHEY, JR., M.D...PP-54.....*Tampa*
ROBERT B. MCIVER, M.D...PP-55.....*Jacksonville*
DUNCAN T. MCEWAN, M.D. (Ex Officio).....*Orlando*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*
HERBERT L. BRYANS, M.D...S.B.H.-54.....*Pensacola*
ERNEST R. GIBSON (Advisory).....*Jacksonville*

*SUB-COMMITTEES

1. Veterans Care

FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
GEORGE M. STUBBS, M.D.....*Jacksonville*
DOUGLAS D. MARTIN, M.D.....*Tampa*
EDWARD F. FOX, M.D.....*Miami*

2. Advisory to National Foundation Infantile Paralysis

FREDERICK H. BOWEN, M.D., Chm.....*Jacksonville*
H. PHILLIP HAMPTON, M.D.....*Tampa*
ROBERT P. KEISER, M.D.....*Coral Gables*
RICHARD G. SKINNER, JR., M.D.....*Jacksonville*

3. Review of Fee Schedules

JOHN D. MILTON, M.D., Chm.....*Miami*
WOODROW B. ESTES, M.D.....*St. Petersburg*
FREDERICK H. BOWEN, M.D.....*Jacksonville*
ODIS G. KENDRICK, JR., M.D.....*Tallahassee*
JAMES B. GLANTON, M.D.....*Orlando*
FLOYD K. HURT, M.D.....*Jacksonville*
HERSCHEL G. COLE, M.D.....*Tampa*
A. FRANKLIN HARRISON, M.D.....*Madison*
JACK O. W. RASH, M.D.....*Miami*
KENNETH S. WHITMER, M.D.....*Miami*
ADELBERT F. SCHIRMER, M.D.....*Orlando*

4. Insurance

SAMUEL M. DAY, M.D., Chm.....*Jacksonville*
COLLIN F. BAKER, M.D.....*Tampa*
JOHN P. FERRELL, M.D.....*St. Petersburg*
ROBERT E. ZELLNER, M.D.....*Orlando*
DE WITT C. DAUGHTRY, M.D.....*Miami*
DALE E. YORK, M.D.....*Pensacola*

5. Blue Shield

LEIGH F. ROBINSON, M.D., Chm.....*Ft. Lauderdale*

SCIENTIFIC WORK

JERE W. ANNIS, M.D., Chm...C-55.....*Lakeland*
SIDNEY DAVIDSON, M.D...AL-54.....*Lake Worth*
FREDERICK K. HERPEL, M.D...D-54.....*W. Palm Beach*
RICHARD C. CUMMING, M.D...B-56.....*Ocala*
ARTHUR J. BUTT, M.D...A-57.....*Pensacola*

LEGISLATION AND PUBLIC POLICY

H. PHILLIP HAMPTON, M.D., Chm...AL-54.....*Tampa*
A. JUDSON GRAVES, M.D...B-54.....*Jacksonville*
ANGUS D. GRACE, M.D...C-55.....*Fort Myers*
DONALD W. SMITH, M.D...D-56.....*Miami*
GEORGE H. GARMANY, M.D...A-57.....*Tallahassee*
FREDERICK K. HERPEL, M.D. (Ex Officio) *W. Palm Beach*
SAMUEL M. DAY, M.D. (Ex Officio).....*Jacksonville*

MEDICAL EDUCATION AND HOSPITALS*

JACK Q. CLEVELAND, M.D., Chm...AL-54....*Coral Gables*
ELBERT MCLAURY, M.D...D-54.....*Hollywood*
S. CARNES HARVARD, M.D...C-55.....*Brooksville*
BENJAMIN F. DICKENS, M.D...B-56.....*Fernandina*
JOSEPH W. DOUGLAS, M.D...A-57.....*Pensacola*

*SPECIAL ASSIGNMENT

1. Urge Gifts to American Medical Education Foundation

PUBLIC RELATIONS*

LEIGH F. ROBINSON, M.D., Chm...AL-54..*Fort Lauderdale*
HOWARD V. WEEMS, SR., M.D...C-54.....*Sebring*
EUGENE G. PEEK, JR., M.D...B-55.....*Ocala*
HENRY L. SMITH, JR., M.D...A-56.....*Tallahassee*
DONALD W. SMITH, M.D...D-57.....*Miami*

*SPECIAL ASSIGNMENTS

1. Rural Educational Program
2. State Education Campaign

NECROLOGY

ALVIN L. STEBBINS, M.D., Chm...A-56.....*Pensacola*
DAVID A. NEWMAN, M.D...AL-54.....*Palm Beach*
WALLACE H. MITCHELL, M.D...D-54.....*Key West*
JOSEPH J. LOWENTHAL, M.D...B-55.....*Jacksonville*
HUGH G. REAVES, M.D...C-57.....*Sarasota*

MEDICAL POSTGRADUATE COURSE

TURNER Z. CASON, M.D., Chm...B-55.....*Jacksonville*
W. WELLINGTON GEORGE, M.D...AL-54....*W. Palm Beach*
J. BROWN FARRIOR, M.D...C-54.....*Tampa*
FRANCIS T. HOLLAND, M.D...A-56.....*Tallahassee*
JAMES C. ROBERTSON, M.D...D-57.....*Vero Beach*

CANCER CONTROL

FRAZIER J. PAYTON, M.D., Chm...D-54.....*Miami*
CHARLES MCD. HARRIS, JR., M.D...AL-54..*W. Palm Beach*
GEORGE W. MORSE, M.D...A-55.....*Pensacola*
WESLEY W. WILSON, M.D...C-56.....*Tampa*
DOROTHY D. BRAME, M.D...B-57.....*Orlando*

MEDICAL ECONOMICS

REUBEN B. CHRISMAN, JR., M.D., Chm...AL-54....*Miami*
HARRISON A. WALKER, M.D...D-54.....*Miami*
WILLIAM H. WALTERS, JR., M.D...C-55.....*Lacoochee*
WILLIAM C. ROBERTS, M.D...A-56.....*Panama City*
J. MAXEY DELL, JR., M.D...B-57.....*Gainesville*

VENEREAL DISEASE CONTROL

MELVIN M. SIMMONS, M.D., Chm...C-55.....*Sarasota*
CLARENCE L. BRUMBACK, M.D...AL-54....*W. Palm Beach*
WILEY M. SAMS, M.D...D-54.....*Miami*
DAVID W. GODDARD, M.D...B-56.....*Daytona Beach*
C. W. SHACKELFORD, M.D...A-57.....*Panama City*

TUBERCULOSIS AND PUBLIC HEALTH*

PHILLIP W. HORN, M.D., Chm...B-57.....*Jacksonville*
RALPH M. OVERSTREET, JR., M.D...AL-54..*W. Palm Beach*
ERASMUS B. HARDEE, M.D...D-54.....*Vero Beach*
LOUIS J. GARCIA, M.D...C-55.....*Tampa*
HARRY S. HOWELL, M.D...A-56.....*Lake City*

*SPECIAL ASSIGNMENT

1. Diabetes Control

STATE CONTROLLED MEDICAL INSTITUTIONS

Samuel G. Hibbs, M.D., Chm...C-55.....*Tampa*
W. Lawson Shackelford, M.D...AL-54..*W. Palm Beach*
James G. Lyerly, M.D...B-54.....*Jacksonville*
William D. Rogers, M.D...A-56.....*Chattahoochee*
Edward H. Williams, M.D...D-57.....*Miami*

MATERNAL WELFARE

E. Frank McCall, M.D., Chm...B-56.....*Jacksonville*
James R. Sory, M.D...AL-54.....*W. Palm Beach*
John N. Sims, Sr., M.D...A-54.....*Live Oak*
Ralph W. Jack, M.D...D-55.....*Miami*
Oren A. Ellingson, M.D...C-57.....*Tampa*

CHILD HEALTH

Warren W. Quillian, M.D., Chm...D-54...*Coral Gables*
C. Jennings Derrick, M.D...AL-54.....*W. Palm Beach*
Daniel F. H. Murphey, M.D...C-55.....*St. Petersburg*
Courtland D. Whitaker, M.D...A-56.....*Marianna*
Ludo von Meysenbug, M.D...B-57.....*Daytona Beach*

CONSERVATION OF VISION

Sherman B. Forbes, M.D., Chm...C-54.....*Tampa*
Bascom H. Palmer, M.D...AL-54.....*Miami*
G. Tayloe Gwathmey, M.D...B-55.....*Orlando*
Mozart A. Lischkoff, M.D...A-56.....*Pensacola*
Younger A. Staton, M.D...D-57.....*W. Palm Beach*

ADVISORY TO WOMAN'S AUXILIARY

C. Robert DeArmas, M.D., Chm...B-55..*Daytona Beach*
L. Washington Dowlen, M.D...AL-54.....*Miami*
James L. Anderson, M.D...D-54.....*Miami*
Taylor W. Griffin, M.D...A-56.....*Quincy*
John S. Helms, Jr., M.D...C-57.....*Tampa*

REPRESENTATIVES TO INDUSTRIAL COUNCIL*

Fred H. Albee, Jr., M.D., Chm...AL-54.....*Orlando*
Chas. L. Farrington, M.D...C-54.....*St. Petersburg*
Charles R. Burbacher, M.D...D-55.....*Coral Gables*
Lee Sharp, M.D...A-56.....*Pensacola*
Frank L. Fort, M.D...B-57.....*Jacksonville*

*SPECIAL ASSIGNMENT

1. *Industrial Health*

COUNCILOR DISTRICTS AND COUNCIL

John D. Milton, M.D., Chm...AL-54.....*Miami*
First—Francis M. Watson, M.D...1-54.....*Marianna*
Second—George S. Palmer, M.D...2-55.....*Tallahassee*
Third—William C. Thomas, Jr., M.D...3-54..*Gainesville*
Fourth—Thomas C. Kenaston, M.D...4-55.....*Cocoa*
Fifth—Clyde O. Anderson, M.D...5-55...*St. Petersburg*
Sixth—Emmett E. Martin, M.D...6-54.....*Haines City*
Seventh—Erasmus B. Hardee, M.D...7-54....*Vero Beach*
Eighth—Russell B. Carson, M.D...8-55..*Ft. Lauderdale*

GRIEVANCE COMMITTEE

Walter C. Payne, M.D., Chm.....*Pensacola*
Robert B. McIver, M.D.....*Jacksonville*
David R. Murphey, Jr., M.D.....*Tampa*
Herbert E. White, M.D.....*St. Augustine*
Joseph S. Stewart, M.D.....*Miami*

ADVISORY TO SELECTIVE SERVICE FOR PHYSICIANS AND ALLIED SPECIALISTS

J. Rocher Chappell, M.D., Chm.....*Orlando*
Thomas H. Bates, M.D...“A”.....*Lake City*
Frank L. Fort, M.D...“B”.....*Jacksonville*
Alvin L. Mills, M.D...“C”.....*St. Petersburg*
John D. Milton, M.D...“D”.....*Miami*

EMERGENCY MEDICAL SERVICE

James V. Freeman, M.D., Chm.....*Jacksonville*
Merritt R. Clements, M.D...“A”.....*Tallahassee*
Vernon A. Lockwood, M.D. “B”.....*St. Augustine*
C. Frank Chunn, M.D...“C”.....*Tampa*
C. Jennings Derrick, M.D...“D”.....*W. Palm Beach*

A.M.A. HOUSE OF DELEGATES

Louis M. Orr, II, M.D., Delegate.....*Orlando*
Joshua C. Dickinson, M.D., Alternate.....*Tampa*
(Terms expire Dec. 31, 1953)
Reuben B. Chrisman, Jr., M.D., Delegate.....*Miami*
Frank D. Gray, M.D., Alternate.....*Orlando*
(Terms expire Dec. 31, 1954)
Herbert L. Bryans, M.D., Delegate.....*Pensacola*
Thomas H. Bates, M.D., Alternate.....*Lake City*
(Terms expire Dec. 31, 1954)

BOARD OF PAST PRESIDENTS

William E. Ross, M.D., 1919.....*Jacksonville*
H. Marshall Taylor, M.D., 1923.....*Jacksonville*
John C. Vinson, M.D., 1924.....*Fort Myers*
John S. McEwan, M.D., 1925.....*Orlando*
H. Mason Smith, M.D., 1926.....*Tampa*
Frederick J. Waas, M.D., 1928.....*Jacksonville*
Julius C. Davis, M.D., 1930.....*Quincy*
William M. Rowlett, M.D., 1933.....*Tampa*
Homer L. Pearson, Jr., M.D., Chm., 1934.....*Miami*
Herbert L. Bryans, M.D., 1935.....*Pensacola*
Orion O. Feaster, M.D., 1936.....*Renton, Wash.*
Edward Jelks, M.D., 1937.....*Jacksonville*
Leigh F. Robinson, M.D., 1939.....*Fort Lauderdale*
Walter C. Jones, M.D., 1941.....*Miami*
Eugene G. Peek, Sr., M.D., 1943.....*Ocala*
John R. Boling, M.D., 1944, 1945.....*Tampa*
Shaler Richardson, M.D., 1946.....*Jacksonville*
William C. Thomas, Sr., M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne, M.D., 1949.....*Pensacola*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey, Jr., M.D., 1951.....*Tampa*
Robert B. McIver, M.D., Secy., 1952.....*Jacksonville*

Frederick Karl Herpel, M.D., President

The Journal of the
Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION
P. O. BOX 1018 JACKSONVILLE, FLORIDA

EDITOR
SHALER RICHARDSON, M.D.

ASSISTANT EDITORS
WEBSTER MERRITT, M.D. FRANZ H. STEWART, M.D.

MANAGING EDITOR
ERNEST R. GIBSON

Associate Editors

Louis M. Orr, II, M.D. Orlando
Joseph J. Lowenthal, M.D. Jacksonville
Jere W. Annis, M.D. Lakeland
Herschel G. Cole, M.D. Tampa
Wilson T. Sowder, M.D. Jacksonville
Carlos P. Lamar, M.D. Miami
Waller C. Payne, M.D. Pensacola

Committee on Publication

Shaler Richardson, M.D., Chairman Jacksonville
Chas. J. Collins, M.D. Orlando
James N. Patterson, M.D. Tampa

Abstract Department

Kenneth A. Morris, M.D., Chairman Jacksonville
Waller C. Jones, M.D. Miami

Frederick Karl Herpel, M.D., President

Dr. Frederick Karl Herpel, the son of Henry and Henrietta Mendel Herpel, was born in Reynoldsville, Pa., on Feb. 2, 1893. He received the A.B. degree from Allegheny College in his native state in 1912, and four years later he was awarded the M.D. degree by The Johns Hopkins University School of Medicine. In 1916-1917 he served an internship in the Hartford Hospital, Hartford, Conn.

Entering military service in August 1917, Dr. Herpel was commissioned as a first lieutenant in the Medical Corps of the United States Army. After graduation from the Army Medical School and completion of postgraduate instruction in military orthopedics at the Harvard Medical School and the Massachusetts General Hospital, he served as orthopedic surgeon at Camp Lee, Va., and orthopedic surgeon and assistant adjutant at the Base Hospital, Camp Upton, N. Y. He was then assigned to Fort Jay, N. Y., where he was successively assistant surgeon and surgeon, also attending surgeon, Eastern Department Headquarters, New York Arsenal, U. S. Disciplinary Barracks and Quartermaster Corps, and then assistant to the Department Surgeon, all on Governors Island.

In August 1919, Dr. Herpel was graduated from the Army School of Roentgenology, Army Medical School, in Washington, D. C., and became chief of X-ray Service at Walter Reed Army General Hospital there. Later he held a similar post for two years at Fitzsimons General Hospital in Denver. He retired from active service with the rank of major in December 1922.

In May 1942 he was recalled to active duty. For more than three years he was stationed at Fort Bragg, N. C., where he served as chief of medical examiners, Induction Station, surgeon, Armed Forces Induction Station, surgeon, Personnel Center, and chief of the X-ray Service. Relieved from active duty in October 1945, he retired with the rank of lieutenant colonel.

Upon his release from military service in 1922, Dr. Herpel engaged in the practice of radiology in Spokane, Wash., for three years before locating in West Palm Beach in April 1926. He was radiologist at The Good Samaritan Hospital from 1926 to 1948 and was chief of staff there in 1946. He has been radiologist to St. Mary's Hospital since its organization in 1939 and to Pine Ridge Hospital since 1950. He is a member of the medical staff of these three hospitals and is consulting radiologist to The Martin County Hospital at Stuart.

A past president of the Palm Beach County Medical Society, Dr. Herpel is a charter member

and also a past president of the Florida Radiological Society. Before becoming President-elect of the Florida Medical Association, he had been Chairman of the Committee on Cancer Control and of the Committee on Scientific Work and had served on the Board of Governors.

He is a Fellow of the American College of Physicians, American College of Radiology, Academy International of Medicine and American Geriatric Society. In addition, he holds membership in the American Roentgen Ray Society, Radiological Society of North America, Southern Medical Association, American Medical Association, Association of Military Surgeons, U. S., Association for the Advancement of Science and Association for the Study of Neoplastic Diseases. Also, he is a Diplomate of the American Board of Radiology.

Prominent locally in civic affairs, Dr. Herpel is a past director of the Chamber of Commerce, a former chairman of the Planning Board and a past president of the Rotary Club. He is a director of the Young Men's Christian Association, a Scottish Rite Mason and a Shriner, a member of Palm Beach Post No. 12 of the American Legion, the Military Order of World Wars, and the Presbyterian Church.

His academic fraternity is Alpha Chi Rho, and his medical fraternity is Pi Mu (Phi Chi). He is a member of the Medical and Surgical Association of his alma mater. Also, he is a Fellow of the American Geographical Society and holds membership in the Army & Navy Club, Washington, D. C. His wide interests include membership on the Medical Advisory Committee, Vocational Rehabilitation Commission, Department of Education of Florida and on the Medical Advisory Committee to the Medical School Study Group, University of Florida.

In 1920, Dr. Herpel and Elisabeth Buckley Ketchin of Tariffville, Conn., were united in marriage. The eldest of their three children, 2nd Lt. William F. Herpel, lost his life in France during World War II. The second son, Henry K. Herpel, resides in West Palm Beach, and the daughter, Gretchen, is now Mrs. Richard H. Franklin of California.

Seventy-Ninth Annual Convention

Again this year attendance at the seventy-ninth annual convention in Hollywood, April 26-29, broke the previous records. The total registration was 1,725. Included in this figure are 1,094 physicians, 17 other guests, 390 members and guests of the Woman's Auxiliary, and 224 representatives of exhibiting firms. Twenty-six other states and Canada, Costa Rica, England and Spain were represented. The complete registration list is published at the end of the proceedings on page 916.

Just prior to the adjournment of the Second House of Delegates, Dr. Frederick K. Herpel of West Palm Beach, who has served the past year as president-elect, was installed as president. At that time he was presented a personal gavel by Dr. Robert B. McIver, retiring president. The gavel is encircled by a silver band engraved with Dr. Herpel's name and the year of his administration.

Other officers elected for the coming year are Drs. Duncan T. McEwan of Orlando, president-elect; Thomas H. Bates of Lake City, first vice president; Russell B. Carson of Fort Lauderdale, second vice president, and Thomas C. Kenaston of Cocoa, third vice president. Re-elected to office were Drs. Samuel M. Day, secretary-treasurer, and Shaler Richardson, editor of The Journal, both of Jacksonville.

Dr. Herpel presented to Dr. McIver the past president's button and certificate of honor. Dr. Herpel paid tribute to Dr. McIver for his many years of service to the Association. He described his term as president as but a continuance of the fine service which has always characterized his leadership.

Four Scientific Assemblies, two General Sessions and two meetings of the House of Delegates were crowded into two and one-half days, Monday morning until Wednesday noon. Dr. Robert B. McIver gave his presidential address at the first meeting of the House of Delegates on Tuesday morning. The guest speaker, Dr. Frank Howard Lahey of Boston, presented a paper during the Second General Assembly, which was held following adjournment of the first meeting of the House of Delegates.

The three reference committees appointed by the president gave careful consideration to committee reports and resolutions presented at the first meeting of the House of Delegates. This dispatching of business at the second meeting of

the House was aided greatly by these committees having studied the measures and having made recommendations.

Due to the great number of firms making application to exhibit, the entire Great Lounge of the Hotel was turned over to the technical exhibits. The scientific exhibits were displayed in the Arcade on the ground floor. Technical exhibitors presented a wealth of information on the latest developments in pharmaceuticals and equipment. The attractively displayed scientific exhibits presented information on many subjects.

On Sunday the facilities of the Hollywood Beach Hotel were taxed to provide assembly rooms for the simultaneous meetings of fifteen specialty groups and the Florida Cancer Council. Several out-of-state speakers who addressed specialty groups also appeared on the Association's scientific program. The annual meeting of the Blue Shield of Florida was held on Wednesday afternoon.

The Association is grateful to the doctors who served on the convention committees on smoker, golf, anglers, Woman's Auxiliary Advisory and the Association dinner, and whose time and effort contributed greatly to the success of the 1953 convention.

Over 1,000 members and guests enjoyed a gala "Millionaires Party" at the Hollywood Beach Hotel pool during the annual smoker on Monday evening. At the Association dinner on Tuesday evening, the huge hotel dining rooms were filled to near capacity. Continuous large attendance at these functions necessitates great care in the selection of convention sites in order that adequate facilities may be available.

Headquarters for the 1954 convention will again be the Hollywood Beach Hotel. The dates for this meeting have been set by the Board of Governors for April 25-28.

Convention Golf Tournament

The Florida Medical Association Golf Tournament was a success again this year with 68 entries. The winning scores were determined on the basis of 18 holes played at the Hollywood Beach Hotel Golf Courses. The prizes were awarded prior to the Annual Dinner and the names of the winners were announced at the Dinner Tuesday evening.

The Orlando Cup for low net scorer was won jointly by Drs. Robert C. Piper of Miami and Joseph W. Taylor, Jr., of Tampa with a tie of 70. The Duval Trophy for low gross scorer was won by Dr. Walter F. Davey of Stuart with 71, and the Keleket X-Ray Trophy, which is awarded annually to a member of the radiological group, was won by Dr. James T. Shelden of Lakeland with a 71.

Runner-up prizes for low gross score were won by Dr. Joseph Hundley of Orlando in second place with a 75, and Dr. Philip J. Chastain of Coral Gables in third place with a 76.

Runner-up prizes for low net score were won by Dr. Wilbur C. Sumner of Jacksonville and Dr. James T. Shelden of Lakeland with 71 in a tie for second place. In a tie for third place were Drs. Julian A. Rickles and Robert M. Harris of Miami and Charles H. Kirkpatrick of Arcadia with 72.

The Orlando Cup was donated by the Orange County Medical Society at the annual meeting of the Florida Medical Association in Orlando in 1931 and has now been competed for twenty times with eighteen different winners. During the war years, 1942, 1943 and 1944, no tournaments were held. The Duval County Society Trophy was donated by that Society in 1952 and has, therefore, been awarded only twice.

Association's New Executive Head

Mr. Ernest R. Gibson was elevated to the position of Acting Managing Director of the Florida Medical Association by the Board of Governors at its first meeting following the recent annual convention. He was selected for this important executive post following the death of Dr. Stewart G. Thompson, who had managed the Association for many years.

Coming to the Association in 1947 to direct the public relations activities, Mr. Gibson is well known to many members over the state. His background of broad educational and premedical training and his wide experience in publicity work served him well in that difficult task. With the reorganization of that phase of the work four years ago, he became Assistant Managing Director and also Assistant Managing Editor of The Journal. His close association with Dr. Thompson across the years in this dual capacity has given him invaluable experience which fits him admirably to carry on the executive duties so vital to the life and progress of the Association. In addi-

tion to these duties he will now serve as Managing Editor of The Journal.

It is fortunate indeed that the Association can turn at this time to this able, experienced young man, yet in his forties, who has been trained in its own executive office and is thoroughly familiar with its organizational setup, its problems and its plans for progress. The members may confidently expect the quality of service commensurate with the needs of the great association it has become.

History-Making Medical Event in Washington

The President of the United States helped the American Medical Association make medical history when on March 14 he addressed the house of delegates of that body on the role of medicine in public affairs. At that time the house of delegates was in special session in Washington to consider a plan for the reorganization of the Federal Security Agency. This fourth special session since the organization of the American Medical Association 106 years ago was historically unique since never before had its house of delegates been addressed by the President of the United States.

In a manner both cordial and warmly informal, President Eisenhower expressed his conviction that the decisions of the meeting, particularly in relation to the functions of government, would reflect what the members believed to be best for the United States. He at once claimed "philosophical bonds" with the physicians of the country in his dislike for compulsion and his dislike for socialism. Remarking that this nation is spending billions to prevent socialism, he emphatically declared the preservation of our traditional system of freedom of enterprise to be the doctrine of the administration, of the Republican party, and of the Republican leaders in the Congress. These persons live by such a philosophy and intend to practice it, he declared. He was confident that the doctors would meet the medical needs of the population, and likewise sure that they could do so better with the cooperation and friendship of the administration rather than by its direction.

Also enthusiastically welcomed was Sen. Robert A. Taft, who praised the profession's fight against socialization of this country and regretted that too few people realize "that the American Medical Association has been on the battle line against the extension of socialization and the federalization of all kinds of activities that properly belong at the state level and properly belong in private hands. He said such leadership should be thanked by everybody in this country who believes in the perpetuation of freedom and a free economic system and a free system in governmental matters in the United States." He then urged support for Reorganization Plan No. 1 of 1953, presented to the Senate and House of Representatives two days previously. Dr. Walter H. Judd, physician-congressman from Minnesota, also urged support for the reorganization plan.

After careful consideration, the house of delegates voted unanimously to support President Eisenhower's proposal to elevate the Federal Security Agency to an executive department. Less than one month later the new Department of Health, Education and Welfare became a reality. Whatever eventuates, may the Federal Security Agency of the Ewing days remain forever gone from the Washington scene.

The New Department of Health, Education and Welfare

Is half a loaf better than a whole loaf? Conceivably, it could be. Certainly it is better than no loaf at all and just as certainly it might prove to be as practical as the whole loaf is idealistic. The administration's new Department of Health, Education and Welfare, headed by Mrs. Oveta Culp Hobby, promises to prove the worth or the fallacy of such reasoning.

For more than three quarters of a century, the American Medical Association has from time to time gone on record in favor of a department of health at executive level. It has consistently fought to obtain for health a status both free from entangling alliances and commensurate with its dignity and importance in the lives of the American people. Twice during the last administration it made every effort to defeat reorganization plans for raising the Federal Security Agency to an executive level. It saw in those plans nothing but political plays to provide increasing political control over medicine.

Why then did its house of delegates vote unanimously at a special session in mid-March to go along with the new administration on its proposal to elevate the Federal Security Agency to departmental status? Why did it not fight the plan this time as before? Because it was not

the same plan. It was, in fact, far different from anything hitherto proposed. This was a step forward, not backward nor to the left. Here was a status of dignity and control over medical affairs never before offered medicine. And here was an opportunity to join hands with a friendly administration to give its constructive proposal a fair trial, even if it was not all the profession had hoped for.

"We have come a long way in the past year," said Dr. Elmer L. Henderson, the past president of the American Medical Association who led the fight against socialism, "and today we are asked to approve of not a full loaf, nor what our goal has been for 79 years, but rather a half loaf. And, gentlemen, I am here to tell you that half a loaf is much better than what we have ever had before. . . . Mrs. Hobby is with the medical profession, and she wants to do what you and what I want done, and the only way that she can clean house over there is by getting this Reorganization Plan over. I think it is up to each and every one of us to get out and help do what we can to aid the Administration in aiding the freedom of this great Republic, not only in medicine but in every other line."

True enough, health, education and welfare have no direct connection. As to subject matter, health is separate, education is separate, welfare is separate. There is, however, one tie which justifies a department for the three — the secondary role of government in their affairs. The purpose of the new department, as expressed by Sen. Robert A. Taft, is "to cover those matters in which the federal government's interest is properly a secondary interest under our Constitution, and to cover those matters where the primary obligation is on the state and the local communities to deal with it. . . . Here is a group of interests where the federal government is not supposed to go out and assume the obligation, the responsibility for the activity, but is simply acting in the proper role of the federal government, as it has in many other places, research, study, providing information, and finally providing assistance where assistance is absolutely necessary to see that a general program required and demanded by public opinion may be carried out."[1]

In the new department the Secretary has a Special Assistant for Health and Medical Affairs, appointed by the President, who, under the Secretary, will endeavor to coordinate all of the medical activities. This special assistant must be a doctor of medicine, selected from recognized leaders in the medical field with wide nongovernmental experience. He is to screen everything pertaining to medical affairs before it reaches the Secretary. The department is not to be departmentalized, thereby confining his activities to that which is mainly health. Instead, along with all medical activities within the department, the health aspects of educational programs and the health implications of social security will come within the scope of his official duties. Included are all medical phases of any activities within education or social security — none of which of course could be brought under an independent department of health. Appropriations and budgets as well as policies will come under his scrutiny. He will represent the Secretary at all interdepartmental meetings featuring health topics and also at congressional hearings when appropriations involving health are under consideration.

Finding itself alone in desiring an independent department of health at a time when the administration and the Congress were endeavoring to reduce and combine independent agencies in the interest of better government, medical leaders chose to cooperate in making the new plan successful, for it seemed a step in the right direction. They, however, reserved the right to make recommendations for amendment of the law, should it not prove a satisfactory solution. "This, of course, would include an effort to establish a separate department of health, should this appear to be essential," said Dr. Louis H. Bauer, President of the American Medical Association. "I am glad to say that the House unanimously approved this recommendation, which I believe was a wise decision, in view of all aspects of the situation. . . . we shall be embarking on a new sea of adventure, and I believe the medical profession of the United States can wield a constructive influence on the health of the American people. I am sure that we shall have every possible cooperation from Washington."[2]

Who knows but that half a loaf among friends may be enough to suffice? Why not keep an open mind on the matter?

1. Address of Hon. Robert A. Taft, J. A. M. A. 151:1201 1203 (April 4) 1953.
2. The President's Page, J.A.M.A. 151:1009 (March 28) 1953.

Gamma Globulin Program for Florida

Of wide interest to the members of the Florida Medical Association is the gamma globulin program for Florida announced by Dr. L. L. Parks, Director, Bureau of Preventable Diseases, Florida State Board of Health. The following memorandum has been sent to all the health officers in the state:

The quantity of gamma globulin being made available to Florida by the Office of Defense Mobilization is based upon the following data:

1. The supply of gamma globulin for use in the control of measles and infectious hepatitis is based upon the median number of cases of measles reported in 1947-1951. A supply for this part of the program is available to the private physicians through the county health departments. The amount is being limited to 10 vials to each county unless a special request is made for additional amounts. At the same time a case report card should be submitted on each case treated, to help justify our request for additional supplies if needed.

The recommended dose of gamma globulin for modification of measles is .02 cc. per pound of body weight. Since the need for such modification is primarily in children the total amount needed will seldom exceed 1 cc. This would be enough to modify the disease in a child of 50 pounds.

The average poliomyelitis prophylactic dose is 0.14 cc. per pound or a 50 pound child would require 7 cc. This dosage gives an average six week period protection. It is given intramuscularly.

The initial allotment of gamma globulin for the control of poliomyelitis was to be furnished the state on or about May 1 within the limits of available supply at that time. The amount allotted to Florida will be calculated on the basis of the median number of reported cases for the years 1947-1951. Again, this emphasizes the need of our receiving reports of all cases of poliomyelitis.

The following are the recommendations for the guidance of the county health departments in the use of gamma globulin in the prophylaxis of poliomyelitis. These are the general recommendations of the State and Territorial Health Officers Association with slight modification by our office:

1. It is recommended that the supply be limited to use in household contacts, 15 years of age and under, of clinically diagnosed cases of poliomyelitis.

2. Use in pregnant household contacts irrespective of age is recommended.

It is recommended that in order to obtain gamma globulin for prophylaxis, the physician should furnish the County Health Director the name, age, sex, color and the date of onset of the case, and should advise if the case is a paralytic or nonparalytic case. He should also report the names, ages and weights of the household contacts to be inoculated. A recommended form for acquiring such information will be submitted at a later date.

Follow-up studies of the efficacy of globulin immunization in household contacts should be instituted.

It is suggested that the County Medical Society have a committee to provide help in reviewing all diagnostic criteria and to encourage the judicial use of gamma globulin within the framework of the state and national policies.

It is also requested that the county health directors report all poliomyelitis deaths promptly, by name and residence, to gage the severity of the epidemic in the counties of the state so as to facilitate the emergency allocation of globulin if available from the national pool.

The inoculation of intimate contacts other than household contacts is not advised at the present time unless a sufficient supply of gamma globulin is made available. Gamma globulin for community prophylaxis will have to depend upon the supply available from the Office of Defense Mobilization, and again the National Headquarters will probably set up certain case rates per population to determine whether we will be entitled to an emergency supply of it or not. Once more, this emphasizes the need of prompt and complete reporting of poliomyelitis cases if we are to obtain additional supplies for such control measures. A statement from the State and Territorial Health Officers on community prophylaxis is as follows: "Community prophylaxis is recommended only in communities that are clearly experiencing unusually severe epidemics early in the season such as the one which occurred in Wytheville, Virginia, in 1950, and for small isolated population groups such as summer camps, nursery schools, and certain institutions where contacts among the children are unusually intimate."

Play Safe with Insecticides in the Home

With the annual spring house cleaning and war against moths now well in hand, the battle against mosquitoes, flies and other summer pests mounts with steadily increasing tempo. There is no shortage of ammunition, but most insecticides are poisonous. They should, therefore, be used with proper precautions, as indicated on the labels of the insecticide containers.

From the United States Department of Agriculture come some common sense rules for the safe use of insecticides in the home.[1] Dr. L. S. Henderson, department entomologist, advises:

Avoid getting the insecticide in food or on dishes, silverware, or cooking utensils.

Wash off immediately with soap and water any concentrated insecticides you spill on yourself.

Avoid unnecessary exposure to dust or spray mist in the air.

Open doors and windows to provide extra ventilation when extensive spraying or dusting is done.

Avoid spraying liquid insecticides into electrical outlets or on exposed connections where you might create a short circuit.

Take care not to apply insecticides having an oil base near fire, flame, or sparks, and do not smoke while applying them.

Dispose of or return to the original container any unused portion after applying an insecticide.

Clean the sprayer or duster, and then wash with soap and water.

Change your clothes if you have spilled insecticide on them.

Keep insecticides where children or pets cannot get to them.

Avoid storing insecticides with foods or where they might be mistaken for food items.

1. Safety Rules for Using Insecticides, Science News Letter, April 11, 1953, p. 229.

Southern Pediatric Seminar

The Southern Pediatric Seminar will hold its thirty-third annual session this summer in Saluda, N. C. Two weeks (July 20 through August 1) will be devoted to pediatrics and one week (August 3 through 8) will be devoted to obstetrics.

This is an institution of which doctors in the South have a right to be proud. It was founded by a Southern doctor; it is owned and operated by Southern doctors, and its faculty members consist of outstanding Southern physicians.

The course consists of lectures, clinics, demonstrations, and clinical pathological conferences. The members of the faculty are equally divided between physicians in teaching positions and physicians in active practice. Ample opportunity is given for discussions in small groups and for the answering of questions. Every effort is made to give the general practitioner the material and information which he needs in his every day practice.

The course is fully accredited by the American Academy of General Practice.

One great feature of the Seminar is that it is held in the cooling atmosphere of the mountains of North Carolina and many physicians make of the occasion a vacation as well as a time for learning, taking their wives and children with them. Provision is made for the housing of families.

Any general practitioner who is anxious to catch up on what is new in the field of pediatrics or obstetrics is urged to write for further information to Dr. D. L. Smith, Registrar, Saluda, N. C.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Valentine Bloch of Miami announce the birth of a son, Craig Jeffrey, on March 26, 1953.

Dr. and Mrs. Cornelius A. Bird of Jacksonville announce the birth of a son, Cornelius Ashley, II, on April 10, 1953.

Deaths — Members

Smith, Clyde F., Miami Beach	Feb. 28, 1953
Simmons, John A., Arcadia	April 25, 1953
Holloway, Luther W., Jacksonville	May 7, 1953

Deaths — Other Doctors

Guild, William A., Chicago	Date Unknown
Sarven, James D., Cleveland, O.	Date Unknown
Forkosh, Sidney R., Venice	March 1, 1953
Morrison, Charles C., Jr., Bar Harbor, Me.	April 13, 1953
Klock, Guy Almeron, Daytona Beach	April 15, 1953
O'Neil Alfred E., Hialeah	April 16, 1953

Medical Officers Returned

Dr. Louis J. Polskin, who entered military service on March 31, 1951, was released from active duty on March 30, 1953 with the rank of Captain, U. S. Army. His address is 1401 S. Florida Ave., Lakeland.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Alspach, Bruce W., Miami
Brock, Benjamin L., Orlando
Cowell, Virginia L., Coral Gables
Cummings, Eugene H., Jacksonville
Doff, Simon D., Ponte Vedra Beach
Drake, Robert E., Winter Park
Gunther, Roy W., Bradenton
Johnston, Marvin H., Green Cove Springs
Jones, Nathaniel H., (Col.), Ocala
Larkin, Matthew A., Miami
Lindau, Warren, Coral Gables
McCorkle, Albert W., Hialeah
Mohler, Floyd W., St. Petersburg
Nadler, Alfred J., Miami
Neill, John S., Bradenton
Pincus, Isidore, Orlando
Waldron, Barzillia R., St. Petersburg
Zinn, Charles J., Fort Lauderdale

STATE NEWS ITEMS

Dr. Frank G. Slaughter of Jacksonville gave a review before members and guests of the Union Congregational Church book club at their regular monthly luncheon meeting in April.

Dr. Egbert V. Anderson of Pensacola spoke on the "New Developments in the Diagnosis and Treatment of Poliomyelitis" at a recent luncheon meeting of the Woman's Auxiliary to the Escambia County Medical Society.

Dr. William H. Turnley of Ocala received an award at the one hundredth anniversary celebration of the University of Florida recently. The centennial awards were given prominent Floridians and alumni in recognition for professional and personal contributions either to the state or to the University.

Dr. H. Marshall Taylor of Jacksonville, recent past president of the American Laryngological Association, attended the seventy-fourth annual meeting of that organization in New Orleans the week of April 26. He also attended the annual meeting of the American Otological Society and of the American Laryngological, Rhinological and Otological Society, in session there during that week. All three of these national specialty societies will come to Florida in 1955 for their annual meetings in Hollywood.

Dr. Vincent P. Corso of Miami appeared in conjunction with the American Cancer Society's two films, "Man Alive," and "Questions in Time," before the Alpha Epsilon Delta Premedical Honorary Fraternity at the University of Miami recently.

Dr. A. Judson Graves of Jacksonville gave a talk on "Cancer" at a recent meeting of the Meninak Club of Jacksonville.

Dr. Joseph J. Lowenthal of Jacksonville attended a course at Cornell University Medical College on "Recent Advances in Internal Medicine."

Drs. John H. Tanous of Miami Beach and Joseph J. Groom of Miami spoke on "Choosing Medicine as a Profession" at the Miami Jackson High School on "Career Day."

Dr. Joseph A. J. Farrington of Jacksonville spoke at the April meeting of the Andrew Jackson P.-T.A.

Dr. Edward Canipelli of Jacksonville spoke on "Cancer" at a recent meeting of the Civitan Club of that city.

Drs. Robert F. Mikell and Herman Selinsky of Miami appeared in a panel discussion on "Behavior Problems" before the Florida Federation of Woman's Clubs.

Drs. Wilson T. Sowder and Gary E. Turner of Jacksonville participated in the annual spring meeting of the Florida Conference of Social Welfare held in Jacksonville in April.

Dr. Donald F. Marion of Miami has been elected as Editor of The Bulletin of the Dade County Medical Association to succeed Dr. Franz H. Stewart who recently resigned.

Dr. Robert E. Blount of Fort Lauderdale, who is Chairman of the Broward County Chapter of the American Cancer Society, recently presented two cancer films before six different civic organizations of women and one "open house" at a local theatre. Following the film presentations to these groups, Dr. Blount conducted a question and answer period concerning the problems of cancer facing American women.

Dr. Leroy H. Oetjen of Leesburg was a recent guest speaker at a meeting of the Leesburg Health Council.

Drs. Thomas H. Odeneal and Wiley T. Simpson of Winter Haven attended the World Medical Association convention in Athens, Greece.

Dr. Arthur Schwartz of Daytona Beach spoke on criminal pathology and its use in courtroom testimony before members of the Stetson University Chapter of Phi Delta Phi legal fraternity recently.

Dr. Leon S. Eisenman of Okeechobee spoke on "The Role of Cytology in the Diagnosis and Treatment of Cancer," at a recent meeting of the Okeechobee Rotary Club.

The A. M. A. Committee on Medical Motion Pictures has announced the publication of a supplement to the list of films available through the motion picture library. This supplement includes 12 motion pictures added to the library since publication of the Dec. 1, 1952 catalog. Copies may be obtained by writing to the Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn St., Chicago 10.

FOUND: Lady's white gabardine jacket left in the dining room at the Hollywood Beach Hotel following the Auxiliary luncheon on Monday, April 27, 1953. Owner please contact Mrs. T. C. Kenaston, Box 552, Cocoa.

Dr. James V. Freeman of Jacksonville spoke on "Cancer" at the March meeting of the North Jacksonville Junior Woman's Club.

Dr. Paul F. Hutchins of Jacksonville has been named to the Executive Board of the Duval County Chapter of the National Polio Foundation.

Dr. Philipp R. Rezek of Miami has been appointed by the College of American Pathologists to serve on the Committee on Forensic Pathology.

Dr. Franklin J. Evans of Coral Gables was a speaker at the recent University of Miami Law School Insurance Conference. His subject was "Medico-Legal Aspects — Disability Evaluation."

Dr. Hugh A. Carithers of Jacksonville spoke on "Behavior Problems in Children," at the April meeting of the Venetia P.-T. A.

Dr. Dale E. York of Pensacola was the speaker at the Kick-Off Breakfast for the cancer campaign at the Allentown School auditorium recently.

Dr. Ashbel C. Williams of Jacksonville spoke at a recent luncheon meeting of the Woman's Club of Jacksonville. His subject was cancer. Following luncheon, a round table forum was held, and Drs. Wilbur C. Sumner and C. Burling Roesch answered questions concerning cancer.

Dr. Alpha N. Herbert of Miami gave the welcome address at the opening meeting of the convention of the Florida League for Nursing in Miami.

Drs. William P. Hixon, Walter B. Tomlinson, Henry M. Yonge, Alpheus T. Kennedy, and Charles A. Patterson of Pensacola, and Dr. William J. Overman of Warrington have been appointed by the Escambia County Medical Society to the Escambia County Heart Association Clinic Committee.

Dr. William H. Walters, Jr., of Lacoochee spoke at recent meetings of the Dade City Rotary and Kiwanis Clubs. He spoke on cancer and the drive for funds.

Dr. James C. Lanier of Jacksonville was guest speaker at the April business and program meeting of the Woman's Club of South Jacksonville. His subject was "Current Ideas in Pediatrics."

Dr. Grayson C. Snyder of Blountstown has been elected president of the Blountstown Rotary Club.

Dr. Arthur J. Butt of Pensacola participated in a Symposium on Renal Calculous Disease at the meeting of the Southeastern Section of the American Urological Association in Havana, Cuba, recently.

Dr. James N. Patterson of Tampa attended the meetings of the International Association of Medical Museums and the American Association of Pathologists and Bacteriologists held at the Jefferson Hotel, St. Louis, March 30 through April 4.

Dr. Jack H. Bowen of Jacksonville spoke on "Lesions of the Hand" at a recent monthly meeting of the staff of the Waterman Memorial Hospital, Eustis. Dr. Jackson L. Allgood, Jr., of Jacksonville, assisted him with the color slide presentation.

Dr. Russell B. Carson of Fort Lauderdale was installed as president of the Southeastern Section of the American Urological Association, at its meeting in Havana, Cuba, March 26-29, 1953. Dr. Milton M. Coplan of Miami is the national committeeman representing the Section to the American Urological Association, and Dr. Perry D. Melvin of Miami is on the executive committee representing Florida.

Dr. Gretchen V. Squires of Pensacola was guest speaker at a recent weekly luncheon meeting of the Junior Chamber of Commerce of that city. She spoke on the danger signals of cancer and the current disease rate in Northwest Florida.

Dr. Paul L. Summers of Melbourne spoke on cancer at a recent meeting of women from the rural areas, and a film on self-examination for cancer was shown.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

FOR RENT: Lincoln Road office, Miami Beach. Waiting room furnished. Reasonable. Write 69-79, P. O. Box 1018, Jacksonville, Fla.

WANTED: Internist or General Practitioner for furnished office in northeast section of Miami. Write 69-80, P. O. Box 1018, Jacksonville, Fla.

LOCATION WANTED: Retired Naval medical officer; experienced administrator; desires position as administrator small hospital; excellent references, available immediately. Write 69-92, P. O. Box 1018, Jacksonville, Fla.

OFFICE POSITION WANTED: Lady, 36, 4½ years medical experience. Assistant — secretary — bookkeeper — receptionist. Give injections. Know how to collect and buy supplies. Can take charge and run office or small clinic. References excellent. Need good salary. Small town preferred. Write 69-93, P. O. Box 1018, Jacksonville, Fla.

LOCATION WANTED—RADIOLOGIST: Board qualified Radiologist available November. Additional two years navy radiology. Desire hospital part time or private office association. Florida Boards. Robert E. Cato, M.D., Grady Hospital, Atlanta, Ga.

FOR SALE: Wonderful location. Used as doctor's office for 35 years. Property extends completely through block. For complete details — description and price — write Joe B. Henderson Agency, 3075 9th St., No., St. Petersburg, Fla.

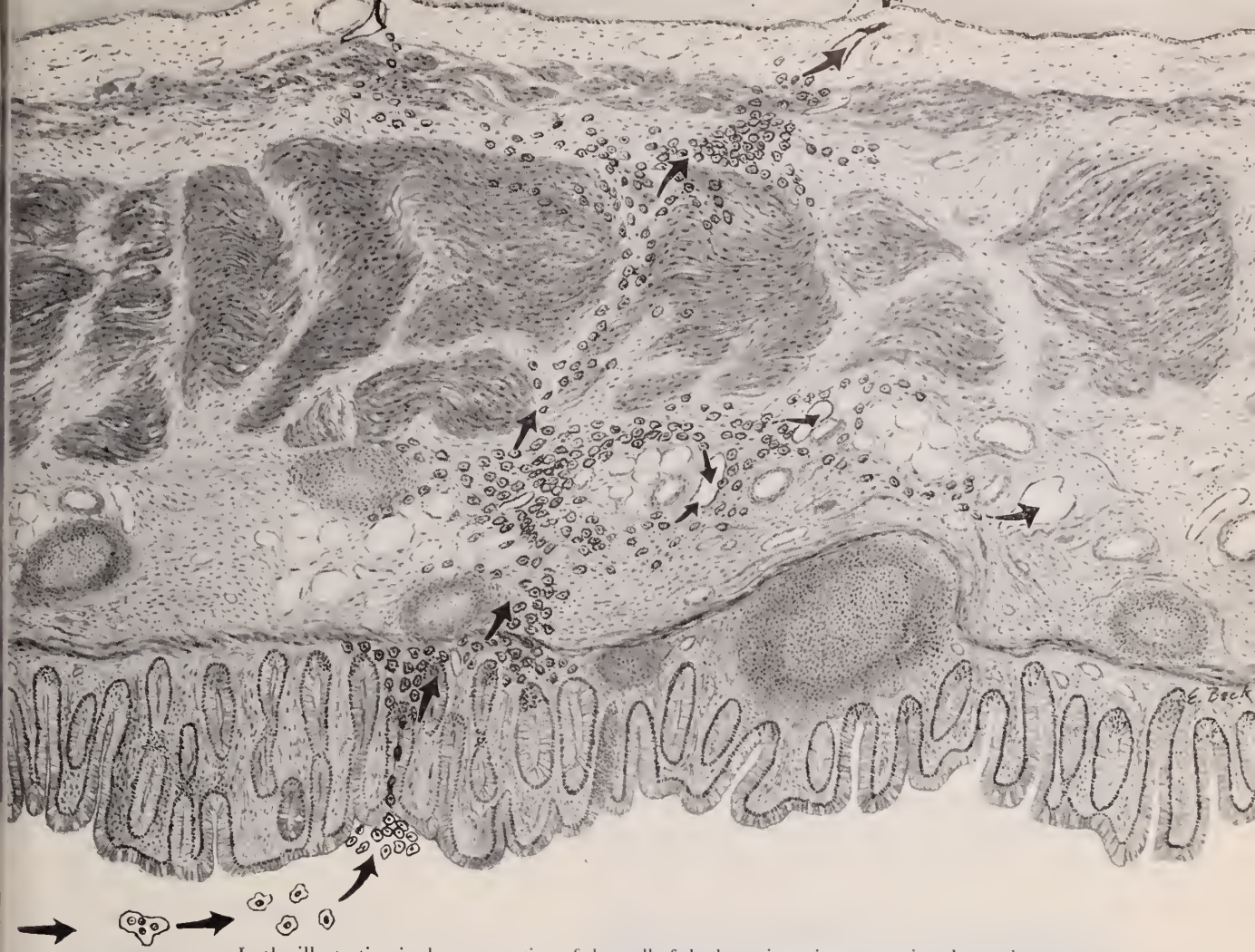
WANTED: Affiliation with group, industry, sanatorium or hospital. Well trained and wide experience. Category IV. Prefer Fort Lauderdale, Florida area. Write 69-94, P. O. Box 1018, Jacksonville, Fla.

PHYSICIAN WANTED: Boca Grande, Florida. Exceptional opportunity for active, capable, general practitioner. House and fully equipped Clinic, including X-ray and Laboratory, all rent free. Contact: Mr. Wiley Crews, Vice President, Boca Grande Health Clinic, Inc., Boca Grande, Fla.

S. A. Kyle *Funeral Director*

MEMBER National Selected Morticians BY INVITATION

17 WEST UNION STREET
JACKSONVILLE 2, FLORIDA
Phones 5-3766 5-3767



In the illustration is shown a section of the wall of the large intestine suggesting the mode of invasion of *Endamoeba histolytica* into the various levels; the mesenteric venules lead to the liver and escape of some of the parasites may cause an amebic abscess of the liver.

Diodoquin® in Amebiasis

"Diodoquin is very effective in curing the intestinal infection...."*

In a recent survey of seven commonly-used amebacides, Weingarten* concluded that Diodoquin (diiodohydroxyquinoline, U.S.P.) gave an excellent percentage of cures with maximal safety for the patient.

The active protozoacidal agent in Diodoquin is iodine, present in the high percentage of 63.9.

As a result of this high iodine content, Diodoquin is extremely potent and, with few exceptions, a twenty-day divided dosage will destroy the offending organisms. This efficient therapeutic effect is due to the high levels of insoluble halogen acting in the lumen of the bowel. It is a well tolerated and relatively nontoxic amebacide.

Diodoquin's simplified dosage plan, three 10-grain tablets daily for twenty days, is a decided improvement for treating both the asymptomatic and symptomatic forms of amebiasis. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. Diodoquin is supplied as tablets of 10 grains (650 mg.) in bottles of 60 and 500.

*Weingarten, M.: Proctology Symposium: Amebiasis: Medical Aspects, Mod. Med. *20*:121 (May 15) 1952.

COMPONENT SOCIETY NOTES

Alachua

At a recent meeting of the Alachua County Medical Society, Herpetologist Ross Allen spoke on reptiles and the Ross Allen Reptile Institute at Silver Springs. He explained that both he and his physicians learned much that is new in the treatment of snake bites recently when he was bitten by a rattlesnake.

Broward

Dr. Louis G. Herrmann, associate professor of surgery at the University of Cincinnati Medical School, spoke on the various aspects of the recognition, prevention and treatment of common peripheral vascular diseases at the April meeting of the Broward County Medical Association. Dr. Dale P. Osborn, president of the Cincinnati Academy of Medicine, introduced the speaker.

Allen's Invalid Home
MILLEDGEVILLE, GA.
Established 1890
For the treatment of
NERVOUS AND MENTAL DISEASES
Grounds 600 Acres
Buildings Brick Fireproof
Comfortable Convenient
Site High and Healthful
E. W. ALLEN, M.D., *Department for Men*
H. D. ALLEN, M.D., *Department for Women*
Terms Reasonable

Dade

At the May meeting of the Dade County Medical Association, a panel discussion of "Chronic Pulmonary Diseases" was held with Dr. M. Jay Flipse as moderator. Doctors participating and their subjects were M. Eugene Flipse, "Medical Aspects;" DeWitt C. Daughtry, "Surgical Aspects;" Alfred G. Levin, "Radiological Aspects," and Nelson Zivitz, "Allergic Aspects."

Duval

At the regular monthly meeting of the Duval County Medical Society on May 5, the following spoke on the Child Guidance Clinic: Dr. Gary E. Turner, Mrs. Virginia M. Wright, MSSW; Haim G. Ginott, Ed.D., and E. L. Flemming, Jr., Ed.D. Drs. Samuel R. Lamb and Allen Marans spoke on "Information on Doctor's Draft."

Hillsborough

At the May meeting of the Hillsborough County Medical Society, Dr. Irving M. Essrig spoke on "Gadgets in Vascular Surgery."

Lake

At a recent meeting, the Lake County Medical Society voted to continue to give the National Guard of Lake County every assistance possible in relation to physical examinations and immunization. The regiment has only 20 per cent of its required physicians and the Eustis unit's nearest assigned Medical Officer is Jacksonville, a distance of 140 miles. The Lake County Medical Society has rendered this service for the past five years.

Index to
Volume XXXIX
Page 947

Marion

The regular monthly meeting of the Marion County Medical Society was held on April 21 at the Hotel Marion in Ocala. Dr. Hawley H. Seiler of Tampa was the guest speaker, and his subject was the more common surgical conditions of the lungs met with by the general practitioner.

Palm Beach

Dr. Willis J. Potts, Chief Surgeon of Children's Memorial Hospital, Chicago, spoke on the latest surgical methods in treating diseases of children, at the March meeting of the Palm Beach County Medical Society.

The Palm Beach County Medical Society has paid 100 per cent of its state dues for 1953.

Pinellas

At the regular monthly meeting of the Pinellas County Medical Society on May 1, Dr. William Bierman, Assistant Clinical Professor, Columbia University College of Physicians and Surgeons, spoke on "Physical Medicine and Rehabilitation in Chronic Neurological Problems of the Older Age Group." He was a guest of the VA Hospital Staff.

The 1953 series of Medical Forums sponsored by the Pinellas County Medical Society and the St. Petersburg Times ended April 2. More than 10,000 persons attended the 13 programs which required more than 100 physicians to stage. Dr. N. Worth Gable, who originated the idea of the Forums, stated that the Society was well pleased with the second annual series, and said a 1954 series would be held.

Polk

The Polk County Medical Society ended its first annual series of Medical Forums April 17 following a session on "The Common Cold." Dr. Jere W. Annis, Lakeland, president of the Society, was moderator, and principal speaker was Dr. George Dormon, Winter Haven. The Lakeland Kiwanis Club and the Lakeland Ledger joined the Society in sponsoring the Forums. Close to 3,000 persons attended the four program series.

Seminole

Members of the Seminole County Medical Society were honored by the Woman's Auxiliary at a dinner party recently. The event was held in celebration of "Doctor's Day."

Just Off the Press!

HEART and CIRCULATION
DIAGNOSIS and TREATMENT

by MEYER SCLAR, M.D., F.A.C.C.

"THIS BOOK was written specially for the General Practitioner and the Medical Student. The basic concepts of diagnosis and treatment, in the field of cardiology, are presented in such a manner that both the physician and student will find their approach to cardiac patients greatly simplified. In a manual of this sort it is impossible to cover the entire field of cardiovascular disease in detail, but an attempt has been made to describe all the commonly found cardiac conditions and their management. The rare and controversial concepts are mentioned more briefly." — *From the author's preface.*

Crown octavo. Finely printed and bound.
352 pages. Fully illustrated.

Price: $7.50

Send your order to:

FROBEN PRESS, INC.
Medical Publishers
1776 BROADWAY, NEW YORK 19, N. Y.

Advertisement

From where I sit *by* Joe Marsh

Pretty "Foxy" Terrier

Talking about dogs the other night —and Sandy Johnson topped everything off with a tall story about his fox terrier, "Boscum."

According to Sandy, "Comes bird season and that dog won't stir if I take down my rifle. *Same if it's deer season and I go for my* shotgun—*he won't move, but he's scratching at the door if I so much as look at my rifle!"*

One day, Sandy decided to fool him. He took down *both* his shotgun and his rifle—and swish, Boscum was on his way! So Sandy put the guns back and took out his fishing rod. He went outside and there was Boscum—digging like crazy for worms!

From where I sit, a dog that can outguess humans is as rare as a human that can outguess other humans. For instance, I like a glass of beer with lunch but I wouldn't pour you one without first asking. I want to practice my profession the way I think best, but I won't tell you how to do your job. Respecting the other's rights keeps freedom from "going to the dogs."

Joe Marsh

Copyright, 1953, United States Brewers Foundation

WOMAN'S AUXILIARY
TO THE
FLORIDA MEDICAL ASSOCIATION

OFFICERS

MRS. THOMAS C. KENASTON, President.....*Cocoa*
MRS. RICHARD F. STOVER, President-elect.....*Miami*
MRS. SAMUEL S. LOMBARDO, 1st Vice Pres....*Jacksonville*
MRS. SCOTTIE J. WILSON, 2nd Vice Pres...*Ft. Lauderdale*
MRS. CURTIS W. BOWMAN, 3rd Vice Pres...*St. Petersburg*
MRS. JAMES T. COOK, JR., 4th Vice Pres.....*Marianna*
MRS. NELSON A. MURRAY, Recording Sec'y...*Jacksonville*
MRS. LEE ROGERS, JR., Correspd. Sec'y.....*Cocoa*
MRS. EDWARD W. CULLIPER, Treasurer.....*Miami*

COMMITTEE CHAIRMEN

MRS. HERSCHEL G. COLE, Parliamentarian.....*Tampa*
MRS. GEORGE H. PUTNAM, Historian.....*Gainesville*
MRS. TAYLOR W. GRIFFIN, Finance.....*Quincy*
MRS. ARTHUR R. KNAUF, Medaux.....*Tampa*
MRS. LAWRENCE R. LEVITON, Legislation..*W. Palm Beach*
MRS. SAMUEL S. LOMBARDO, Organization....*Jacksonville*
MRS. HERBERT B. LOTT, Program.....*Tampa*
MRS. FRED MATHERS, Public Relations.....*Orlando*
MRS. GORDON H. IRA, Revisons.....*Jacksonville*
MRS. CHARLES McD. HARRIS, JR., Today's Health.....*W. Palm Beach*
MRS. RALPH S. SAPPENFIELD, Amer. Med. Ed. Found.....*Miami*
MRS. ARTHUR C. TEDFORD, Bulletin.....*Melbourne*
MRS. SHERREL D. PATTON, Civil Defense.....*Sarasota*
MRS. MAURICE P. COOPER, Stu. Nurse Recruit....*Miami*
MRS. RALPH S. SAPPENFIELD, Stu. Loan Fund.....*Miami*
MRS. C. ROBERT DeARMAS, Auxiliary Writer for State Medical Journal.....*Daytona Beach*
MRS. A. FRED TURNER, JR., Hospitality.....*Orlando*
MRS. RALPH S. SAPPENFIELD, Study Group.....*Miami*

Taking Stock of Ourselves

As the annual convention concludes another year in Auxiliary work, it is customary and wise to glance backward in order to go forward with better perspective and with confidence. It is a time of inventory — the time to weigh as well as to measure organizational growth in relation to its progress, for one determines the course of the other in many instances.

The reports given by our President, State Officers, Chairmen and County Presidents are the cumulative result of sincere effort and good work, indicative, not only of interest, but of efficiency as well as talent. It was a good year. Congratulations to the doctors' wives who have done their work well and good wishes to those who embark on new courses.

In taking stock, however, we cannot content ourselves with the successes we have achieved, limiting our appraisal to strength and new growth. To continue the ascent in a growing organization we can recognize that as we grow we become vulnerable to new errors. We cannot expect to climb without a stumble or expand without creating gaps. So with the same objective analysis and good will we can take courage to recognize a weakness when it develops.

A weakness in a structure wherein each unit is dependent upon the other must be spotted and strengthened or a strain will undermine the whole. The weak spot at present is in the department of nominations. The repair crew chief called in and able to adjust it is the Study Group Chairman.

That department should and could be utilized to know your organization, to understand the limitations of Chairmanships as well as capacities. There is too much tendency in organizations to judge the progress of the group by its size. Because we are large does not mean we are necessarily maturing in proportion to our growth. It merely imposes an obligation upon us to tread with care because more is expected of us.

An active study group in each county would reveal the nature of our group. Who are we? What do we stand for? The purpose, objectives, function and procedures could be understood by all. No group who understood the facts about an organization which is still in the stages of appealing to the greater percentage of doctors' wives for membership and cooperation could believe there is the faintest reason to contest for office in its administration.

The "push and shove" technic for position common in many organizations is out of place in a group dedicated to the ideal to welcome the doctor's wife and to promote trust and friendly relationships among those who gather in convention. We are gathered in force to promote his interest and to fight a common enemy and are weakened when we divide in order to have enemies in common.

A nominating committee is as useless without timely help from the counties as a hospitality committee is with no guests to prepare for. The appeals made through the Journal articles, at the fall board meeting and through letters, as well as the very function of a five member committee, indicate that representation from each area is desirable. It is a medium to activate each section. When those appeals are ignored in some areas a slate is made up of the areas who do cooperate. We have no way to compel participation, no way to induce cooperation when it counts.

The use of surprise nominations from the floor which is acceptable in parliamentary procedure and is democratic in principle is a device instituted to protect the rights of the individual from a pressure group. It is availed of by those who feel it necessary to work independently of the nominating committee and suggests a spirit in a group which divides it against itself. It is indicative of being out of touch with the committee and its solemn obligation to serve the group to the best of its ability and certainly out of sympathy with the committee.

Mrs. Thomas C. Kenaston
President, Woman's Auxiliary

When distrust is sowed by implication in the assembly the smile fades in the corridor. For when a group witnesses a nominating committee who, in the absence of information feels it has all the suggestions the state has to offer, with confidence presents the slate, only to find to its confusion and discomfort that another has been in operation, the atmosphere changes and tension sets in. Suggestion of friction and visions of caucus with its attendent whispering and maneuv-

Twenty-Seventh Annual Meeting
Woman's Auxiliary to
The Florida Medical Association
Hollywood, April, 1954

ering rises like a spectre among the assembled. Uneasiness creates reticence. Some members become confused. Some members become discouraged and a large segment retire to the relaxing atmosphere of social amiability which the cabanas by the pool offer, to re-establish the instinctive desire we all have to make and keep friends.

A nominating committee can and should be given the names of all candidates eligible so that a double or triple slate can be presented with pride and in unison. All candidates for office should be aware of the circumstances so that each can enter into or retire from the spirit of competition depending upon her nature.

We cannot invite counties of different ages and sizes, equipped with varying degrees of information to come to a convention celebration offering assistance, common purpose and hospitality and then spring a game of skill and contest upon them with the rules known only to a few — not without a disturbing reaction, at least.

So with a renewed desire to foster the good will which is the motivating purpose of our Auxiliary, we have discovered a source of friction, outlined its cause and effect, and prescribed a remedy. But, remember, your Study Group Chairman is as helpless as other chairmen. She cannot assist you unless you indicate a wish to have assistance. She cannot answer questions which haven't been asked.

So in taking stock we realize that the mistakes we make are not permanent unless we evade the opportunities to amend them. One false note cannot destroy the harmony of a whole song when everybody tries to keep in tune.

Mrs. C. Robert DeArmas

BOOKS RECEIVED

Brain Surgeon, the Autobiography of William Sharpe. Pp. 271. Price, $3.75. New York, The Viking Press, 1952.

One who has often held life and death in his hands tells with warm humility the story of his extraordinary career as a pioneer neurosurgeon of his day. Here is an American saga of a rise from comparative poverty to the pinnacle of success.

Much of Dr. Sharpe's life story reads like fiction — sometimes fantastic fiction: his success at tutoring what he calls "slothful students" at Harvard; his associations with students, professors, and women during the year he spent at a famous German medical school and in Italy; his trying experiences as assistant to the famous but often irascible Dr. Harvey Cushing at Johns Hopkins; his year as a young medic in China, during which he performed a delicate and successful brain operation on the son of the first President of the Chinese Republic, for which he received an unsolicited fee of $50,000.

A particularly appealing part of the book is the account of his increasing fight against cerebral palsy. By a series of unprecedented tests Dr. Sharpe demonstrated how easy it is, granted immediate treatment, to remove the dread condition, in most cases entirely. As a result of half a century of research and practice Dr. Sharpe has contributed perhaps more than any other living man to the advance in knowledge of how to combat such dire human ills as cerebral palsy and hydrocephalus.

Its important medical revelations, together with the qualities of humanity and humility, the sense of drama and lively humor, make this an outstanding American autobiography. In the words of Dorothy Canfield Fisher, "It is a privilege to share Dr. Sharpe's stirring life in this honest, pungent, vivid account of a distinguished doctor's long service to humanity."

BISCAYNE HOSPITAL
6339 Biscayne Blvd.
MIAMI 38, FLORIDA

Members of the Dade County Medical Association are acquainted with the high type of service rendered.

David Collins, Superintendent

Registered, American Medical Association
Phone 7-4544

CONVENTION PRESS
218 WEST CHURCH STREET
JACKSONVILLE
FLORIDA

Commercial and
Publication
Printing

Index to Volume XXXIX

Abdominal Tumors — A Urologic Perspective (abst) 107
Accessory Spleens, Location, and Technical Aspects of Splenectomy (scientific) 338
Accident Toll in Children (edit) 839
Accidents Among Florida Children Leading Cause of Death (scientific) 97
Acute Craniocerebral Injuries (scientific) 264
Adams-Stokes Syndrome (scientific) 811
Agranulocytosis and Miscellaneous Manifestations — Hypersplenism (scientific) 334
All That Paper Work (edit) 839
Allergy, Childhood, Importance of Early Treatment in Modifying and Preventing Adult Allergic Disorders (scientific) 741
Allergy from the Otolaryngologist's Viewpoint (abst) 744
Allergy Survey of Florida in the Light of Present Knowledge (scientific) 38

American Medical Association:
A.M.A. Annual Meeting, New York, June 1-5, 1953 (commentary) 844
A.M.A. Clinical Session, Denver, December 2-5 (commentary) 359
A.M.A. Convention, Big and Busy (commentary) 119
A.M.A. Coordinating Committee Disbands, Whitaker and Baxter Resign (commentary) 358
A.M.A. President September Visitor to Florida (commentary) 198
Clinical Session, Denver, Dec. 2-5, 1952, Report of Delegates (commentary) 677
Denver A.M.A. Clinical Session (commentary) 601
Dr. Bauer, A.M.A. President, Addresses Florida Medical Committee for Better Government (commentary) 281
History-Making Medical Event in Washington (edit) 934
Placement Assistance for Physicians (edit) 442
Pointed Testimony (commentary) 52
Registration, Florida Doctors, 1952 A.M.A. Convention (commentary) 120
Report of Delegates to A.M.A., Chicago, June 9-13, 1952 (commentary) 199
Well Done, Whitaker and Baxter (commentary) 359

American Medical Education Foundation, Plans for 1953 Campaign (commentary) 767
American Way — An Evaluation (From Our President) 110
Anal Sphincter, Incontinence of the, Surgical Treatment of a Patient with, Following Ureterosigmoidostomy (abst) 595
Anemia, Hemolytic (scientific) 327
Anesthetic Agents, Local, Use of Antihistamines (scientific) 505
Aneurysm, Healed Dissecting, Coexisting with Sacular Thoracic Aneurysm and Ruptured Abdominal Aneurysm: Report of Case (scientific) 495
Anthrax, Management of an Outbreak (scientific) 403
Antihistamines as Local Anesthetic Agents for Urethral Manipulation (abst) 834
Antihistamines, Use of as Local Anesthetic Agents (scientific) 505
Antituberculosis Drugs (edit) 51
Apoplexy, Intra-Abdominal, Report of Case (scientific) 652
Approval for Internships Changed (edit) 676
Articles Concerning Stress and the Adaptive Hormones (commentary) 767
Association's New Executive Head (edit) 933

Baby Feeding, Further Observations on a New Concept (scientific) 21
Barium Enema Fluid, Intraperitoneal Escape, in Perforation of Sigmoid Colon (abst) 834
Basic Policy for Gamma Globulin Distribution (commentary) 844
Bauer, Dr., A.M.A. President, Addresses Florida Medical Committee for Better Government (commentary) 281
Bilateral Abductor Paralysis of the Vocal Cords, Intralaryngeal Arytenoidectomy (scientific) 647
Blakeslee, Howard, Posthumous Award (commentary) 119
Blood Transfusion Problems (scientific) 173
Blue Shield:
Blue Shield Benefits 204
Doctor's Service Report 53
Message to Blue Shield Physicians 360
Bones Changes, Interesting, in Plain Urograms (abst) 595

Books received:
Bowen, Carroll T.: Handbook on V.D. 539
Council on Pharmacy and Chemistry, American Medical Association: New and Nonofficial Remedies, 1952 456
Dublin, Louis I.: A 40 Year Campaign Against Tuberculosis 617
Greenblatt, Robert B.: Office Endocrinology 128
Hardy, James C.: Surgery and the Endocrine System, Physiologic Response to Surgical Trauma — Operative Management of Endocrine Disorders 61
Hildreth, Dorothy Myers, and Hildreth, Eugene A.: The Low Fat Diet Cookbook 540
Hyndman, Olan R.: Origin of Life and the Evolution of Living Things, An Environmental Theory 128
Kaehele, Edna: Living with Cancer 617
Krupp, Marcus A.; Sweet, Norman J.; Jawetz, Ernest, and Armstrong, Charles D.: Physicians Handbook 617
London, Louis S.: Dynamic Psychiatry, Basic Principles 61
London, Louis S.: Dynamic Psychiatry. Transvestism — Desire for Crippled Women 456

(Continued on page 948)

MIAMI MEDICAL CENTER

P. L. DODGE, M.D.
Medical Director and President

1861 N. W. South River Drive
Phones 2-0243 — 9-1448

A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures — Psychotherapy, Insulin, Electroshock, Hydrotherapy, Diathermy and Physiotherapy when indicated. Adequate facilities for recreation and out-door activities. Cruising and fishing trips on hospital yacht.

Information on request
Member American Hospital Association

(Continued from page 947)

McDonald, Joseph J., and Chusid, Joseph G.: Correlative Neuroanatomy and Functional Neurology 687
Millman, Milton: Pardon My Sneeze 687
Research Division, S. B. Penick & Co.: Bacitracin, A Review and Digest of the Literature Up to and Including January 1952 456
Selye, Hans: Annual Report on Stress 61
Selye, Hans: Story of the Adaptation Syndrome (Told in the Form of Informal Illustrated Lectures) 540
Selye, Hans, and Horava, Alexander: Second Annual Report on Stress 774
Sharpe, William: Brain Surgeon, the Autobiography of William Sharpe 946
Woods Schools, Child Research Clinic: Helping Parents Understand the Exceptional Child 539

Bricker Resolution (edit) 766
Buphthalmos: Results from Operative Procedures Particularly Cyclodiathermy: Report of Six Cases (abst) 513

Cancer and Diabetes Control Program, State, Study of Medical Indigence Based Upon (scientific) 507
Cancer Council, Florida, Annual Meeting Held (commentary) 679
Cancer Seminar, Southeastern States, Tampa, Oct. 30-Nov. 1 (commentary) 278
Carcinoma of Prostate, Proctologic Manifestations (abst) 594
Carcinoma of the Prostate Treated by Estrogen, Histological Studies (abst) 351
Cardioinhibitory Effects of Carotid Sinus Pressure (scientific) 416
Cardiosplanchic Reflex, Surgical Significance (abst) 351
Carotid Sinus, Its Clinical Importance (abst) 745
Carotid Sinus Pressure, Cardioinhibitory Effects (scientific) 416
Case of Patient Versus Case (edit) 357
Cerebral Blood Flow and Metabolism, Factors Influencing, A Review (abst) 744

Cerebral Blood Flow and Metabolism in Pernicious Anemia (abst) 592
Cerebral Circulation and Metabolism, Human, Review of the Effects of Various Drugs (scientific) 817
Changing Disease Pattern (commentary) 51
Changing Income Distribution (edit) 196
Charcot Joints and Infectious-vascular Lesions of Bones in Diabetes Mellitus (abst) 429
Children, Florida, Accidents Among, Leading Cause of Death (scientific) 97
Cholecystitis, Acute, Management (scientific) 91
Citizens First (From Our President) 274
Citrus Grove Operations, in 1951, Parathion Poisoning (scientific) 655
Civil Defense Manual on Matching Funds Program (commentary) 600
Civil Defense Medical Supplies (edit) 276
Clinics, Tumor, Revaluation (commentary) 680
Comparable Hourly Earnings for Physician and Skilled Laborer (edit) 676
Congenital Cardiac Disease, Disturbances of Cardiac Rhythm and Conduction: Report of 5 Cases (abst) 594
Convention, A.M.A., Big and Busy (commentary) 119
Convention Golf Tournament (edit) 932
Convention, Seventy-Ninth Annual, Proceedings 893
"Coronary Disease" of the Inner Ear: The Vascular Origin of Vertigo and Deafness (scientific) 269
Correspondence 603
Correspondence: Explanation — Annual Registration with State Board of Health 526
Corticotrophic Preparation, Long-Acting, Experiences with the Therapeutic Use (scientific) 167
Cortisone and ACTH, Use, in a Case of Eclampsia (scientific) 578
County Cares for its Psychotics (abst) 831
County Health Unit, Scientific Critique of Progress (scientific) 582
Coxsackie Group of Viruses, Relationship to Vesicular Pharyngitis (abst) 107
Craniocerebral Injuries, Acute (scientific) 264
Cystic Disease of the Lungs (abst) 835
Cysto-Urethroscope, Air, New Female (abst) 513

Deafness and Vertigo, Vascular Origin of: "Coronary Disease" of the Inner Ear (scientific) 269

Deaths:
Members:
Adams, C. LeRoy, Jr., Live Oak 205, 534
Anderson, James M., Cross City 444, 614
Blessing, Robert, Fort Lauderdale 603, 688
Bradley, James A., St. Petersburg 210
Brantley, James W., Grandin 121
Carefoot, George H., Fort Meade 53, 124
Carter, George W., Chipley 53, 290
Clemmer, Charles A., Ormond Beach 530, 616
Coogler, Adrian C., Brooksville 121, 288
Cordes, Henry B., Frostproof 845
Dawkins, N. J., Vernon 768
Early, Charles S., Lakeland 530, 615
Harrison, M. M., Bradenton 284, 613
Holloway, Ellis W., Tampa 680
Holloway, Luther W., Jacksonville 937
Hopkins, William B., Tampa 53, 287
Kay, Milton B., Miami Beach 444, 853
Logie, Arthur J., Miami 121, 288, 369
McDuffie, Harold F., Jacksonville 369
McKenzie, Albert C., Jacksonville 205
McKinley, Frank J., Tampa 680
McKinnon, Daniel A., Marianna 845
Miles, Walter G., Chattahoochee 768
Mills, Herbert R., Tampa 205, 368
Moore, Thomas J., St. Petersburg 768
Owens, W. Duncan, Warrington, Va. 284, 454
Parnell, Henry E., Perrine 211
Paulk, George A., Miami 768
Pay, Wilson C., DeLand 284, 613
Perdue, John Randolph, Miami 58
Perez, Joseph, DeLand 845
Petteway, Charles H., Lakeland 444, 536

Richardson, James C., Miami 53, 287
Ricker, Samuel F., Orlando 284, 455
Riesenbeck, Leo H., Miami 205, 288
Simmons, John A., Arcadia 937
Skiff, Francis S., Fort Lauderdale 205, 533
Smith, Clyde F., Miami Beach 937
Sperry, Herbert G., Coral Gables 284, 534
Spiers, W. Henry, West Palm Beach 530, 855
Stollenwerck, A. D., Jacksonville 205, 533
Taylor, Joseph E., DeLand 205, 453
Thomson, William Ross, Miami Beach 59
Throne, Binford, Bradenton 603
Tillman, George C., Clearwater 205, 452
Weems, William H., West Palm Beach 284, 534
Wilkins, Walter E., Jacksonville 768
Winchester, Harold E., Dunedin 530, 689

Other Doctors:
Abrams, Marc V., Miami Beach 603
Bartee, L. H., Port St. Joe 768
Clark, George T., Bradenton 205
Crossley, Elijah R., Chicago 845
Currence, John D., New York 680
Dudley, Ervin F., Okeechobee 121
Elsen, Matt, Winnebago, Ill. 845
Faletti, Anthony J., Miami 121
Forkosh, Sidney R., Venice 937
Gardner, Otho W., Greensboro 680
Gauzza, Valentine P., Miami Beach 530
Guild, William A., Chicago 937
Holly, Julius D., Baltimore, Md. 680
Ives, W. M., Lake City 845
Kerr, James E., Winston-Salem, N. C. 768
Klock, Guy Almeron, Daytona Beach 937
McKey, Earle S., Jr., Valdosta, Ga. 361
Meyers, Max I., Columbia, Pa. 530
Morrison, Charles C., Jr., Bar Harbor, Me. 937
O'Neil, Alfred E., Hialeah 937
Pearson, Richard J., Tampa 444
Sarven, James D., Cleveland, O. 937
Scurry, B. C., (Col.), Cocoa 444
Shanks, Edgar D., Atlanta, Ga. 845
Thomson, Hubert O., Tyler Tex. 284
Vogt, Elkin, Lithonia, Ga. 284
Weaver, Cleo Earl, LaBelle 205
White, Russell P., Flomaton, Ala. 680
Woods, E. Bryant, Atlanta, Ga. 530

Defense, Civil, Medical Supplies (edit) 276
Deficiency, Mental (scientific) 589
Delegates and Committee Chairmen, Notice (commentary) 675
Delegates to A.M.A., Denver, Dec. 2-5, 1952, Report (commentary) 677
Denver A.M.A. Clinical Session (commentary) 601
Dermatologic Dangers of Sunlight (scientific) 249
Diabetes and Cancer Control Program, State, Study of Medical Indigence Based Upon (scientific) 507
Diabetes Association, Florida Clinical, Schedule for First Annual Meeting (commentary) 842
Diabetes Mellitus, Charcot Joints and Infectious-vascular Lesions of Bones (abst) 429
Diabetic Neuropathy (scientific) 500
Disease Pattern, Changing (commentary) 51
Disk, Ruptured Intervertebral, Pitfalls in the Surgery (scientific) 159
District Meetings, Medical, October 27-31, 1952 (commentary) 280
Disturbances of Cardiac Rhythm and Conduction in Congenital Cardiac Disease: Report of 5 Cases (abst) 594
Dr. Bauer, A.M.A. President, Addresses Florida Medical Committee for Better Government (commentary) 281
Dr. Henry Perrine, Versatile Florida Pioneer (edit) 45
Doctor Looks Ahead (edit) 765
Drugs, Antituberculosis (edit) 51
Drugs, New, "Miracle" and Otherwise, For Tuberculosis (scientific) 37
Drugs, Review of Effects of Various, on Human Cerebral Circulation and Metabolism (scientific) 817
Duodenum, Prolapse of Gastric Mucosa into: Report of Eight Cases (scientific) 25
Ear, Inner, "Coronary Disease": Vascular Origin of Vertigo and Deafness (scientific) 269
Earnings, Comparable Hourly, for Physician and Skilled Laborer (edit) 676
Eclampsia, Use of Cortisone and ACTH in a Case (scientific) 578
Education, Graduate Medical (commentary) 204, 444, 677, 768
Effect of Hyaluronidase on Urine and its Possible Significance in Renal Lithiasis (abst) 891
Effect of Intravenous Papaverine Hydrochloride on the Cerebral Circulation (abst) 427
Electric Vaporizing Device for Insecticides Present Health Hazards (edit) 357
Electrolyte and Fluid Therapy, Rational and Scientific Method for Evaluating, Postoperatively (scientific) 815
Endocrinology, Postgraduate Assembly, Miami Beach, November 3-8 (commentary) 279
Enterogastrone Parenterally in the Treatment of Peptic Ulcer: A Controlled Clinical Study (abst) 428
Erythroblastosis Fetalis, Exchange Transfusion (scientific) 259
Estrogen, Histological Studies of Carcinoma of the Prostate Treated by (abst) 351
Evaluation of Liver Biopsy as a Diagnostic Procedure (abst) 426
Evaluation of the Treatment of Thyroiditis (abst) 428
Exchange Transfusion in Erythroblastosis Fetalis (scientific) 259
Exhibit, F.M.A., at Orlando Fair (commentary) 843
Experience with Peritoneoscopy in Duval County (scientific) 643
Experiences with the Therapeutic Use of a Long-Acting Corticotrophic Preparation (scientific) 167
Extracranial Metastases with Intracranial Tumors (abst) 833
Facial Bones, Fractures — Standardization of Diagnosis and Treatment (abst) 832

(Continued on page 950)

Cook County Graduate School of Medicine

POSTGRADUATE COURSES — 1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting June 15, July 6, August 3. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting August 3. Surgical Anatomy & Clinical Surgery, Two Weeks, starting June 15, August 17. Fractures & Traumatic Surgery, Two Weeks, starting June 15. Esophageal Surgery, One Week, starting June 22. Breast & Thyroid Surgery, One Week, starting June 22. Gallbladder Surgery, Ten Hours, starting June 29. Surgery of Colon & Rectum, One Week, starting September 21. Basic Principles in General Surgery, Two Weeks, starting September 21. General Surgery, One Week, starting October 5. General Surgery, Two Weeks, starting October 12. Thoracic Surgery, One Week, starting October 12.

GYNECOLOGY—Intensive Course, Two Weeks, starting June 15, September 21. Vaginal Approach to Pelvic Surgery, One Week, starting September 14.

OBSTETRICS—Intensive Course, Two Weeks, starting October 5.

MEDICINE—Intensive General Course, Two Weeks, starting October 12. Electrocardiography & Heart Disease, Two Weeks, starting July 13. Allergy, One Month and Six Months, by appointment.

CYSTOSCOPY—Ten-Day Practical Course starting every two weeks.

UROLOGY—Intensive Course, Two Weeks, starting September 28.

Teaching Faculty:

Attending Staff of Cook County Hospital

Address:

Registrar, 707 South Wood Street,

Chicago 12, Illinois

(Continued from page 949)

Factors Influencing Cerebral Blood Flow and Metabolism, A Review (abst) 744
Fatalities from Hydrogen Sulfide in Wells (abst) 41
Federal Thought Control a Challenge to American Liberties and Freedom (scientific) 179
Feeding, Baby, Further Observations on a New Concept (scientific) 21
Feeding the Critically Ill, New Regimen, Preliminary Report (abst) 595
Femur, Use of Prostheses in the Head and Neck (scientific) 487
Fixation, Intramedullary, of Fractures of Long Bones (scientific) 820
Florida, Allergy Survey, in the Light of Present Knowledge (scientific) 38
Florida Cancer Council Annual Meeting Held (commentary) 679
Florida Medical Committee for Better Government, Dr. Bauer, A.M.A. President, Addresses (commentary) 281
Florida Pollen Study (abst) 429
Florida Society of Ophthalmology and Otolaryngology Holds Midwinter Convention (commentary) 678
Fluid and Electrolyte Therapy, Rational and Scientific Method for Evaluating, Postoperatively (scientific) 815
F.M.A. Exhibit at Orlando Fair (commentary) 843
Fractures, Badly Comminuted, Treatment with the Rush Nail (scientific) 727
Fractures of the Facial Bones — Standardization of Diagnosis and Treatment (abst) 832
Fractures of Long Bones, Intramedullary Fixation (scientific) 820
Fractures, Pott's, and Associated Injuries (scientific) 732

From Our President:

American Way — An Evaluation 110
Citizens First 274
Greatest Instrument of All 672
Holiday Message 432
Laughter Oils Life's Engine 44
Medical Education Crusade 188
On To Hollywood, April 26-29 748
Ring Out the Old, Ring In the New 516
What Do You Think? 354
Women Physicians — A Salute 598

Funnel Chest, Surgical Correction (abst) 892
Further Observations on a New Concept of Baby Feeding (scientific) 21

Gamma Globulin Distribution, Basic Policy (commentary) 844
Gamma Globulin, Observations Relating to the Use in Prevention of Paralytic Poliomyelitis (commentary) 204
Gamma Globulin Production, Red Cross Finances (commentary) 601
Gamma Globulin Program for Florida (commentary) 936
Gastric Mucosa, Prolapse, into the Duodenum: Report of Eight Cases (scientific) 25
Gastroenterology, Seminar (commentary) 842
General Sessions, Seventy-Ninth Annual Meeting 893
Golf, Convention Tournament (edit) 933
Good Reading for Americans (edit) 50
Graduate Medical Education 204, 444, 677, 768
Graduate Short Course for Doctors of Medicine, Twenty-First Annual, Lecturers (commentary) 840
Greatest Instrument of All (From Our President) 672
Guest Speaker, Annual Convention, 1953, Frank Howard Lahey, M.D. 673

Headache Problem and the Otolaryngologist (scientific) 491
Healed Dissecting Thoracic Aneurysm, Coexisting with Saccular Thoracic Aneurysm and Ruptured Abdominal Aneurysm: Report of Case (scientific) 495
Heart Disease Incidence in School Children of Pensacola, Florida (scientific) 30
Heart Patient, Quiet for (edit) 277
Hemolytic Anemia (scientific) 327
Herpel, Frederick Karl, President (edit) 931
Histological Studies of Carcinoma of the Prostate Treated by Estrogen (abst) 351
History-Making Medical Event in Washington (edit) 934
Holiday Message (From Our President) 432
Hollywood — Convention City 658
House of Delegates, Proceedings, Seventy-Ninth Annual Meeting 895
How Much for Operating Expenses, Doctor? (edit) 676
"How Sick is Socialized Medicine?" (edit) 442
Hoxsey Cancer Case, Important Court Decision (edit) 356
Human Poisoning from Toxaphene (edit) 519
Hydrogen Sulfide in Wells, Fatalities (abst) 41
Hypersplenism — Agranulocytosis and Miscellaneous Manifestations (scientific) 334
Hypersplenism, Pathology (scientific) 341
Hypersplenism, Symposium (scientific) 327
Hypertension Pendulum (edit) 111

Ileal Duplications (abst) 833
ILO — Danger Ahead! (edit) 278
Importance of Early Treatment of Childhood Allergy in Modifying and Preventing Adult Allergic Disorders (scientific) 741
Important Court Decision in Hoxsey Cancer Case (edit) 356
Incidence of Heart Disease in School Children of Pensacola, Florida (scientific) 30
Indigence, Medical, Based Upon the State Cancer and Diabetes Control Program (scientific) 507
Influenza and Pneumonia (edit) 675
Inhibition of the Clot-Accelerating Property of Ingested Fat by Simultaneous Feeding of Sugar (abst) 835
Insecticides, Electric Vaporizing Devices, Present Health Hazards (edit) 357
Interesting Bone Changes in Plain Urograms (abst) 595
Internships, Approval, Changed (edit) 676

• In MIAMI
SANITARIUM
Medical Hospital American Plan
Hotel for Patients and their families.
REST, CONVALESCENCE, ACUTE and
CHRONIC MEDICAL CASES. Elderly
People and Invalids. *FREE Booklet!*

Acres Tropical Grounds, Delicious Meals,
Res. Physician, Grad. Nurses, Dietitian.

SUN-RAY PARK HEALTH RESORT

Mild Mental Cases,
Drug and Alcoholics
in Separate Building

Intra-Abdominal Apoplexy, Report of Case (scientific) 652
Intracranial Tumors with Extracranial Metastases (abst) 833
Intralaryngeal Arytenoidectomy in Bilateral Abductor Paralysis of the Vocal Cords (scientific) 647
Intramedullary Fixation of Fractures of Long Bones (scientific) 820
Intraperitoneal Escape of Barium Enema Fluid in Perforation of Sigmoid Colon (abst) 834

Iodism (abst) 745
Jejunum, Primary Ulcer (abst) 513
Jingle Bells (edit) 441

Keeping Eternally Vigilant (edit) 599
Kidney-Stone Formation, Urinary Colloids in Prevention (abst) 512
Korean Casualties (commentary) 521

Lahey, Frank Howard, M. D., Guest Speaker 673
Laryngeal Paralysis, Bilateral, Progress in the Surgical Treatment (abst) 185
Larynx, Total Removal, and Speech Rehabilitation (abst) 593
Larva Migrans, Treatment with Stibanose, Preliminary Report (abst) 351
Laughter Oils Life's Engine (From Our President) 44
Lecturers for Twenty-First Annual Graduate Short Course for Doctors of Medicine (commentary) 840
Leprosy in Florida (scientific) 573
"Let's All Eat Dirt" (edit) 517
Liver Biopsy, Evaluation, as a Diagnostic Procedure (abst) 426
Lobotomy in Mental Disorders, Results (abst) 833
Low Salt Syndrome (scientific) 411
Lungs, Cystic Disease (abst) 835
Lymphoblastomatosis (abst) 833
Lymphocytoma of the Skin, Report of an Unusual Case (Lymphocytoma Tumidum) (abst) 428
(Lymphocytoma Tumidum), Lymphocytoma of the Skin, Report of an Unusual Case (abst) 428

(Macrocytic) Anemia, Pernicious, of Pregnancy (scientific) 407
Management of Acute Cholecystitis (scientific) 91
Management of an Outbreak of Anthrax (scientific) 403
Management of Thrombocytopenic Purpura, A Condensed Review (scientific) 330
Medical District Meetings, October 27-31, 1952 (commentary) 280
Medical District Meetings, 1952 (commentary) 524
Medical Education Crusade (From Our President) 188
Medical Licenses Granted 291, 777
Medical Management of Renal Lithiasis (abst) 428
Medical Men and Medical Events in British East Florida (edit) 433
Medical Men and Medical Events in Early St. Augustine (edit) 112
Medical Officers Returned 53, 205, 444, 528, 683, 845, 937

Meetings:
A. M. A. Annual meeting, New York, June 1-5, 1953 844
A. M. A. Clinical Session, Denver, December 2-5 359
A. M. A. Convention Big and Busy 119
A. M. A. President September Visitor to Florida (Third Annual Meeting, Florida Medical Committee for Better Government) 198
American Medical Education Foundation Plans for 1953 Campaign 767

(Continued on page 952)

HILL CREST SANITARIUM

FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

Thoroughly modern in architecture and construction. Eight departments — affording proper classification of patients All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

James A. Becton, M.D., Physician-in-charge — James Keene Ward, M.D., Associate Physician

P. O. Box 2896, Woodlawn Station, Birmingham, Alabama — Phones 9-1151 and 9-1152

Whenever the diet is faulty, the appetite poor, or the loss of food is excessive

through vomiting or diarrhea—

Valentine's
MEAT EXTRACT

stimulates the appetite,

increases the flow of digestive juices,

provides: supplementary amounts of vitamins, minerals and soluble proteins,

extra-dietary vitamin B_{12},

protective quantities of potassium, in a palatable and readily assimilated form.

***Supplied** in bottles of 2 fluidounces.*

***Dosage** is 1 teaspoonful two or three times daily; two or three times this amount for potassium therapy.*

VALENTINE Company, Inc.
RICHMOND 9, VIRGINIA

(Continued from page 951)

Denver A. M. A. Clinical Session ... 601
Dr. Bauer, A. M. A. President, Addresses Florida Medical Committee for Better Government ... 281
Florida Cancer Council Annual Meeting Held ... 679
Florida Society of Ophthalmology and Otolaryngology Holds Midwinter Convention ... 678
Graduate Medical Education ... 204, 444, 677, 768
Lecturers for Twenty-First Annual Graduate Short Course for Doctors of Medicine ... 840
Medical District Meetings, October 27-31, 1952 ... 280
Medical District Meetings 1952 ... 524
Midwinter Seminar in Ophthalmology and Otolaryngology, Miami Beach, Jan. 12-17, 1953 ... 443
New Orleans Graduate Medical Assembly ... 444
Postgraduate Assembly in Endocrinology, Miami Beach, November 3-8 ... 279
Proceedings of Seventy-Ninth Annual Meeting ... 887
Program of the Seventy-Ninth Annual Meeting ... 660
Registration at Annual Meeting ... 916
Registration, Florida Doctors, 1952 A. M. A. Convention ... 120
Report of Delegates to A. M. A., Denver, Dec. 2-5, 1952 ... 677
Report of Delegates to A. M. A., June 9-13, 1952 ... 199
Schedule for First Annual Meeting of the Florida Clinical Diabetes Association ... 842
Schedule for Short Course ... 841
Seminar on Gastroenterology ... 842
Seventh Midwinter Seminar in Ophthalmology and Otolaryngology ... 678
Seventy-Ninth Annual Convention ... 932
Seventy-Ninth Annual Meeting ... 674
Southeastern States Cancer Seminar, Tampa, Oct. 30-Nov. 1 ... 278
Southern Medical Association Meeting, Miami, November 10-13 ... 279
Southern Medical Association Forty-Sixth Annual Meeting, Miami, November 10-13 ... 521
Southern Pediatric Seminar ... 937
Meningiomas of the Brain, Subjective and Objective Criteria in the Diagnosis, Remarks as to Mortality and Useful Survival (abst) ... 834
Mental Deficiency (scientific) ... 589
Metabolism and Cerebral Circulation, Human, Review of the Effects of Various Drugs (scientific) ... 817
Midwife Problem, Our (scientific) ... 585
Midwinter Seminar in Ophthalmology and Otolaryngology, Miami Beach, Jan. 12-17, 1953 (commentary) ... 443
Neuropathy, Diabetic (scientific) ... 500
Neurosurgical Aspects of Spontantous Subarachnoid Hemorrhage (abst) ... 427
New Department of Health, Education and Welfare (edit) ... 934
New Drugs, "Miracle" and Otherwise, for Tuberculosis (scientific) ... 37
New Female Air Cysto-Urethroscope (abst) ... 513
New Horizons (edit) ... 518
New Members 53, 205, 286, 361, 444, 531, 604, 680, 769, 845, 938
New Orleans Graduate Medical Assembly (commentary) ... 444
New Regimen in Feeding the Critically Ill, Preliminary Report (abst) ... 595
New World (edit) ... 189
Nonspecific Granuloma of Rectum and Sigmoid Colon, Lesions of Rectum and Sigmoid Colon Which Clinically Simulated Cancer but Which Responded to Aureomycin Therapy (abst) ... 427
North Florida Fair Exhibit (commentary) ... 520
Note on New Drugs, "Miracle" and Otherwise, for Tuberculosis (scientific) ... 37
Notice to Delegates and Committee Chairmen (commentary) ... 675
Observations Relating to the Use of Gamma Globulin in Prevention of Paralytic Poliomyelitis (commentary) ... 204

On To Hollywood, April 26-29 (From Our President) 748
Operating Expenses, How Much, Doctor? (edit) 676
Ophthalmology and Otolaryngology, Florida Society, Holds Midwinter Convention (commentary) 678
Ophthalmology and Otolaryngology, Seventh Midwinter Seminar (commentary) 678
Otitis Externa (scientific) 729
Otolaryngologist and Headache Problem (scientific) 491
Our Midwife Problem (scientific) 585

Palliative Treatment of Prostatic Cancer (abst) 892
Papaverine Hydrochloride, Effect on the Cerebral Circulation (abst) 427
Paralysis Caused by Penicillin Injection; Mechanism of Complication — A Warning (abst) 350
Parathion Poisoning in Citrus Grove Operations in 1951 (scientific) 655
Parotid Tumors, Surgery (scientific) 414
Pathology of Hypersplenism (scientific) 341
Patient's Judgment on Medical Emergency Verified (edit) 600
Pediatric Seminar, Southern (commentary) 937
Pediatric Trends and Changing Concepts (edit) 838
Penicillin Injection, Paralysis Caused by; Mechanism of Complication — A Warning (abst) 350
Pensacola, Florida School Children, Incidence of Heart Disease (scientific) 30
Peptic Ulcer, Enterogastrone Parenterally in the Treatment: A Controlled Clinical Study (abst) 428
Periodic Physical Examinations Required (commentary) 52
Peritoneoscopy in Duval County, Experience (scientific) 643
Pernicious Anemia, Cerebral Blood Flow and Metabolism (abst) 592
Pernicious (Macrocytic) Anemia of Pregnancy (scientific) 407
Perrine, Dr. Henry, Versatile Florida Pioneer (edit) 45
Pharyngitis, Vesicular, Its Relationship to the Coxsackie Group of Viruses (abst) 107
Phase of Postpartum Bleeding with Case Reports (scientific) 739
Pheochromocytoma: Report of a Malignant Case (abst) 41
Physical Examinations, Periodic, Required (commentary) 52
Pitfalls in the Surgery of the Ruptured Intervertebral Disk (scientific) 159
Placement Assistance for Physicians (edit) 442
Play Safe With Insecticides in the Home (commentary) 937
Pneumonia and Influenza (edit) 675
Pointed Testimony (commentary) 52
Poisoning, Parathion, in Citrus Grove Operations in 1951 (scientific) 655
Poisoning, Reports, Sought (edit) 277
Poliomyelitis, Paralytic, Observations Relating to the Use of Gamma Globulin in the Prevention (commentary) 204
Pollen Study, Florida (abst) 429
Postgraduate Assembly in Endocrinology, Miami Beach, November 3-8 (commentary) 279
Posthumous Award to Howard Blakeslee (commentary) 119
Postoperative Treatment Following Prostatic Surgery (abst) 594
Postpartum Bleeding, Phase, With Case Reports (scientific) 739
Pott's Fractures and Associated Injuries (scientific) 732
Pregnancy, Pernicious (Macrocytic) Anemia (scientific) 407
Prescription Regulations (edit) 519
President, A. M. A., Dr. Bauer, Addresses Florida Medical Committee for Better Government (commentary) 281
President, A. M. A., September Visitor to Florida (commentary) 198
President's Address, Robert B. McIver, M.D. 887

(Continued on page 954)

BRAWNER'S SANITARIUM

ESTABLISHED 1910

SMYRNA, GEORGIA

(Suburb of Atlanta)

For the Treatment of

Psychiatric Illnesses and Problems of Addiction

Psychotherapy, Convulsive Therapy, Recreational and Occupational Therapy

Modern Facilities

Custodial Care for a Limited Number of Elderly Patients at Monthly Rate

JAS. N. BRAWNER, M.D.
Medical Director

Jas. N. BRAWNER, JR., M.D.
Assistant Director and Superintendent

ALBERT F. BRAWNER, M.D.
Resident Superintendent

P. O. Box 218

Phone 5-4486

(Continued from page 953)

President's Page (From Our President):
American Way — An Evaluation 110
Citizens First 274
Greatest Instrument of All 672
Holiday Message 432
Laughter Oils Life's Engine 44
Medical Education Crusade 188
On To Hollywood, April 26-29 748
Ring Out the Old, Ring in the New 516
What Do You Think? 354
Women Physicians — A Salute 598

Present Status of Phrenic Nerve Paralysis in the Treatment of Pulmonary Tuberculosis (abst) 512
Primary Ulcer of the Jejunum (abst) 513
Problem of "Sore Throat" with Special Reference to Modern Therapy (abst) 513
Proceedings of Seventy-Ninth Annual Meeting 893
Proctologic Manifestations of Carcinoma of the Prostate (abst) 594
Program of the Seventy-Ninth Annual Meeting 660
Progress in the Surgical Treatment of Bilateral Laryngeal Paralysis (abst) 185
Progress, Scientific Critique of, in a County Health Unit (scientific) 582
Prolapse of the Gastric Mucosa into the Duodenum: Report of Eight Cases (scientific) 25
Prostate, Carcinoma, Proctologic Manifestations (abst) 594
Prostate Carcinoma, Treated by Estrogen, Histological Studies (abst) 351
Prostatic Cancer, Palliative Treatment (abst) 892
Prostatic Surgery, Postoperative Treatment (abst) 594
Prostheses, Use, in the Head and Neck of the Femur (scientific) 487
Psittacosis (abst) 513
Psychosomatic Aspects of Multiple Sclerosis (abst) 831
Psychotics, County Cares for (abst) 831
Pulmonary Tuberculosis, Present Status of Phrenic Nerve Paralysis in the Treatment (abst) 512
Purpura, Thrombotic Thrombocytopenic (scientific) 101

Quiet for Heart Patient (edit) 277
Quo Vadis (edit) 275

Rational and Scientific Method for Evaluating Fluid and Electrolyte Therapy Postoperatively (scientific) 815
Rectum and Sigmoid Colon, Nonspecific Granuloma, Lesions of Rectum and Sigmoid Colon Which Clinically Simulated Cancer But Which Responded to Aureomycin Therapy (abst) 427
Red Cross Finances Gamma Globulin Production (commentary) 601
Registration at Annual Meeting 916
Registration, Florida Doctors, 1952 A. M. A. Convention (commentary) 120
Registration, Florida Doctors, Southern Medical Association Forty-Sixth Annual Meeting, Miami, November 10-13 (commentary) 522
Registration, Medical District Meetings 1952 (commentary) 524
Renal Lithiasis, Effect of Hyaluronidase on Urine and Possible Significance (abst) 891
Renal Lithiasis: Its Treatment and Prevention by Increasing the Protective Urinary Colloids with Hyaluronidase (abst) 592
Renal Lithiasis, Medical Management (abst) 428
Renal Lithiasis, Role of Protective Urinary Colloids in Prevention (abst) 832
Report of Delegates to A. M.A., Chicago, June 9-13, 1952 (commentary) 199
Report of Delegates to A. M. A., Denver, Dec. 2-5, 1952 (commentary) 677
Reports, Annual:
Editor 925
Secretary-Treasurer and Managing Director 919
Reports on Poisoning Sought (edit) 277
Results of Lobotomy in Mental Disorders (abst) 833
Retinal Detachment, Spontaneous Reattachment Following Aureomycin Therapy (abst) 185
Revaluation of Tumor Clinics (commentary) 680

BALLAST POINT MANOR

Care of Mild Mental Cases, Senile Disorders
and Invalids
Alcoholics Treated

Aged adjudged cases will be accepted on either permanent or temporary basis.

ACCREDITED HOSPITAL FOR NEUROLOGICAL PATIENTS by
American Medical Assn.
American Hospital Assn.
Florida Hospital Assn.

5226 Nichol St.
Telephone 62-2332

DON SAVAGE
Owner and Manager

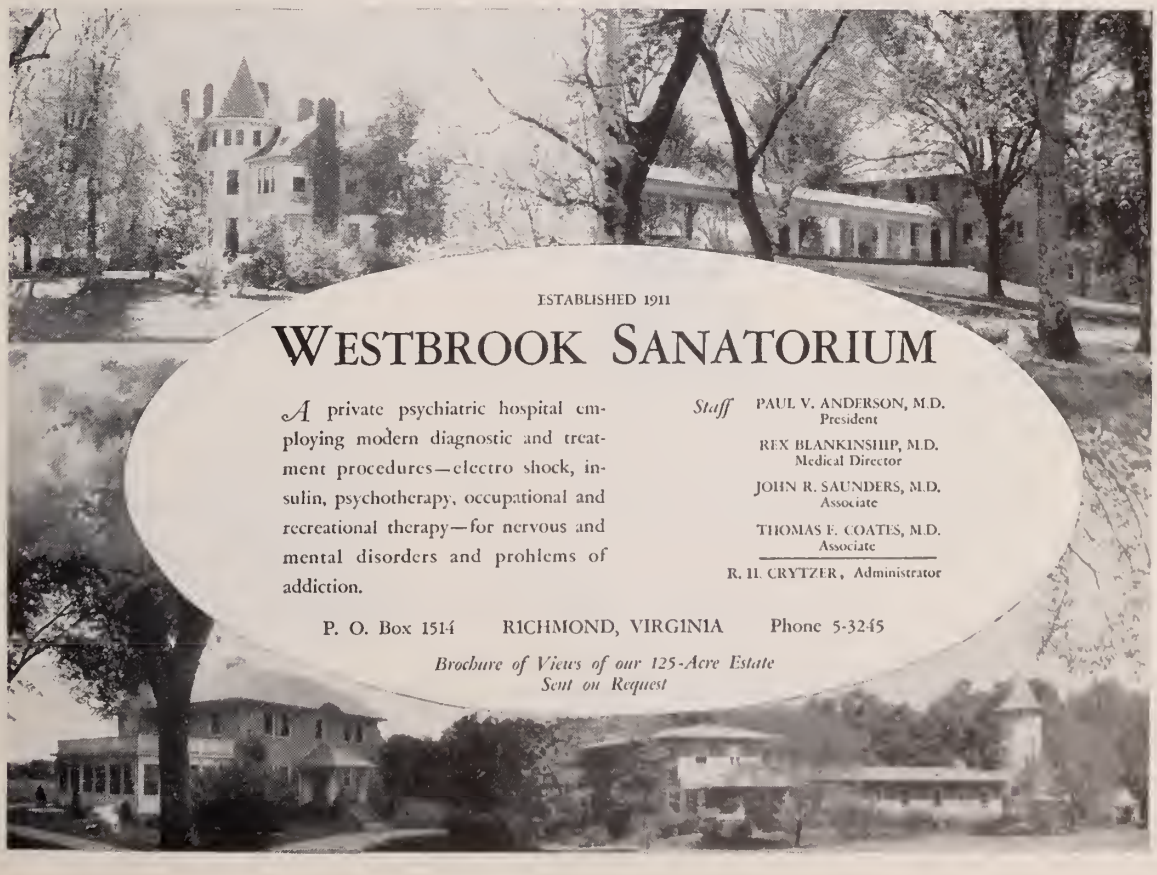
P. O. Box 10368
Tampa 9, Florida

Review of the Effects of Various Drugs on Human Cerebral Circulation and Metabolism (scientific) 817
Ring Out the Old, Ring in the New (From Our President) 516
Road Slaughter (edit) 117
Roentgen Examination of the Spleen (scientific) 337
Role of Protective Urinary Colloids in Prevention of Renal Lithiasis (abst) 832
Ruptured Intervertebral Disk, Pitfalls in the Surgery (scientific) 159
Rush Nail, Treatment of Badly Comminuted Fractures (scientific) 727

Salt Syndrome, Low (scientific) 411
Schedule for First Annual Meeting of the Florida Clinical Diabetes Association (commentary) 842
Schedule for Short Course (commentary) 841
School Children of Pensacola, Florida, Incidence of Heart Disease (scientific) 30
Scientific Assemblies, 79th Annual Convention 915
Scientific Critique of Progress in a County Health Unit (scientific) 582
Sclerosis, Multiple, Psychosomatic Aspects (abst) 831
Seminar on Gastroenterology (commentary) 842
Seventh Midwinter Seminar in Ophthalmology and Otolaryngology (commentary) 678
Seventy-Ninth Annual Convention (edit) 932
Seventy-Ninth Annual Meeting (commentary) 674
Side Entrance Technic (edit) 118
Sigmoid Colon and Rectum, Nonspecific Granuloma, Lesions of Rectum and Sigmoid Colon Which Clinically Simulated Cancer But Which Responded to Aureomycin Therapy (abst) 427
Sigmoid Colon, Perforation, Intraperitoneal Escape of Barium Enema Fluid (abst) 834
Socialized Medicine:
A. M. A. Coordinating Committee Disbands, Whitaker and Baxter Resign (commentary) 358
Bricker Resolution (edit) 766
Dr. Bauer, A. M. A. President, Addresses Florida Medical Committee for Better Government (commentary) 281
Doctor Looks Ahead (edit) 765
Federal Thought Control a Challenge to American Liberties and Freedom (scientific) 179
"How Sick is Socialized Medicine?" (edit) 442
ILO - Danger Ahead! (edit) 278
New Department of Health, Education and Welfare (edit) 934
New Horizons (edit) 518
Side Entrance Technic (edit) 118
Straws in the Wind (edit) 765
Taking Stock (edit) 355
Well Done, Whitaker and Baxter (commentary) 359

"Sore Throat" Problem with Special Reference to Modern Therapy (abst) 513
Southeastern States Cancer Seminar, Tampa, Oct. 20-Nov. 1 (commentary) 278
Southern Medical Association Meeting, Miami, November 10-13 (commentary) 279
Southern Medical Association Forty-Sixth Annual Meeting, Miami, November 10-13 (commentary) 521
Southern Pediatric Seminar (commentary) 937
Specialty Group Meetings, Program 666
Speech Rehabilitation After Total Removal of Larynx (abst) 593
Spermatic Cord, Tumors, Review of Literature and Report of Two Cases (abst) 426
"Spirit Incorruptible" (commentary) 602
Spleen, Roentgen Examination (scientific) 337
Splenectomy, Technical Aspects, and Location of Accessory Spleens (scientific) 338
Spontaneous Subarachnoid Hemorrhage, Neurosurgical Aspects (abst) 427

(Continued on page 956)



(Continued from page 955)

State Board of Health:
Reporting of Communicable Diseases 528
Treatment of Selected Cancer Patients at Oak Ridge Institute of Nuclear Studies 284
Static Electricity Dangers (edit) 197
Stokes-Adams Syndrome (scientific) 811
Straws in the Wind (edit) 765
Stress and the Adaptive Hormones, Articles Concerning (commentary) 767
Study of Medical Indigence Based Upon the State Cancer and Diabetes Control Program (scientific) 507
Subjective and Objective Criteria in the Diagnosis of Meningiomas of the Brain, with Remarks as to Mortality and Useful Survival (abst) 834
Subnormal Response to Cream in Cancer Patients (abst) 891
Sunlight, Dermatologic Dangers (scientific) 249
Surgery of the Parotid Tumors (scientific) 414
Surgery, of Ruptured Intervertebral Disk, Pitfalls (scientific) 159
Surgical Correction of Funnel Chest (abst) 892
Surgical Management of a Patient with Incontinence of the Anal Sphincter Following Ureterosigmoidostomy (abst) 595
Surgical Methods and Results in the Management of Intractable Esophageal Achalasia (abst) 892
Surgical Significance of the Cardiosplanchnic Reflex (abst) 351
Symposium on Hypersplenism (scientific):
Discussions 344
Introduction 327

Tachycardia, Ventricular, Treatment, Report of a Resistant Case (scientific) 422
Taking Stock (edit) 355
Technical Aspects of Splenectomy and Location of Accessory Spleens (scientific) 338
Technical Exhibit 669
Thompson, Stewart Gordon, In Memoriam (edit) 926
Thought Control, Federal, A Challenge to American Liberties and Freedom (scientific) 179
Thrombocytopenic Purpura, Management, A Condensed Review (scientific) 330
Thrombocytopenic Purpura, Thrombotic (scientific) 101
Thrombotic Thrombocytopenic Purpura (scientific) 101
Thyroiditis, Evaluation of the Treatment (abst) 428
Tick Paralysis, Report of a Case in Florida (abst) 185
Training in the Care of the Injured (edit) 441
Transfusion, Blood, Problems (scientific) 173
Transfusion, Exchange, in Erythroblastosis Fetalis (scientific) 259
Treatment of Badly Comminuted Fractures with the Rush Nail (scientific) 727
Treatment of Larva Migrans with Stibanose, Preliminary Report (abst) 351
Treatment of Ventricular Tachycardia, Report of a Resistant Case (scientific) 422
Tuberculosis, Note on New Drugs, "Miracle" and Otherwise (scientific) 37
Tumor Clinics, Revaluation (commentary) 680
Tumors, Abdominal — A Urologic Perspective (abst) 107
Tumors of the Spermatic Cord, Review of Literature and Report of Two Cases (abst) 426
Twenty-First Annual Graduate Short Course for Doctors of Medicine, Lecturers (commentary) 840
Typhoid Carriers (scientific) 580

Urinary Colloids in the Prevention of Kidney-Stone Formation (abst) 512
Urinary Colloids, Role of Protective, in Prevention of Renal Lithiasis (abst) 832
Urograms, Plain, Interesting Bone Changes (abst) 595

TUCKER HOSPITAL, INC.

212 West Franklin Street

Richmond, Virginia

A private hospital accepting for diagnosis and treatment organic neurological conditions, selected psychiatric and alcoholic cases, metabolic disturbances of an endocrine nature, individuals who are having difficulty with their personality adjustments, and children with behavior problems. Patients with general medical disorders admitted for treatment under our staff of visiting physicians.

Under the Professional Charge of

Dr. Howard R. Masters,
Dr. James Asa Shield and Associates

Use of Antihistamines as Local Anesthetic Agents (scientific) 505
Use of Cortisone and ACTH in a Case of Eclampsia (scientific) 578
Use of Prostheses in the Head and Neck of the Femur (scientific) 487

Ventricular Tachycardia, Treatment, Report of a Resistant Case (scientific) 422
Vertigo and Deafness, Vascular Origin: "Coronary Disease" of the Inner Ear (scientific) 269
Vesicular Pharyngitis, Its Relationship to the Coxsackie Group of Viruses (abst) 107
Vocal Cords, Intralaryngeal Arytenoidectomy in Bilateral Abductor Paralysis (scientific) 647

Well Done, Whitaker and Baxter (commentary) 359
Wells, Hydrogen Sulfide in, Fatalities (abst) 41
West Florida, Three Centuries Under Four Flags, Conquest and Disease (edit) 749
What Do You Think? (From Our President) 354
Whitaker and Baxter Resign, A. M. A. Coordinating Committee Disbands (commentary) 358
Whitaker and Baxter, Well Done (commentary) 359
Woman's Auxiliary:
April Invitation 776
How Do We Get That Way? 690
Lamp Lighters 126
Organizational Boomerang 212
Program, Twenty-Sixth Annual Meeting 691
Taking Stock of Ourselves 944
Time Has Come 366
Time To Give 538
Wagon Train 60
Workshop Plan 450
Woman's World? (edit) 840
Women Physicians — A Salute (From Our President) 598

Index to Authors

Articles

Badger, Lucius F., Atlanta, Ga. 573
Baker, Lenox D., Durham, N. C. 732
Barr, James R., Jacksonville 173
Bernstein, Clarence, Orlando 38
Brumback, Clarence L., West Palm Beach 585
Burtner, O. Whitmore, Miami 330
Carithers, Hugh A., Jacksonville 97
Clements, Merritt R., Tallahassee 739
Clifford, William J., North Miami 91
Cole, Herschel G., Tampa 487
Cronkite, Alfred E., Fort Lauderdale 403
Davidson, Sidney, Lake Worth 500
Dell, J. Maxey, Jr., Gainesville 337
Edwards, Thomas M., Tampa 647
Ellis, John T., Dothan, Ala. 820
Evans, Raymond L., Miami 652
Graettinger, John S., Pensacola 30
Grau, Sidney, St. Petersburg 811
Graybiel, Ashton, Pensacola 30
Griffiths, J. T., Jr., Lake Alfred 655
Griffitts, James J., Miami 259
Hilger, Jerome A., St. Paul, Minn. 269
Howdon, William M., Miami 578
Hughes, Paul W., Fort Lauderdale 403, 582
Johnson, V. Marklin, West Palm Beach 341
Kaplan, Sherman R., Miami Beach 327
Kay, John H., Panama City 815
Keschner, Harold W., North Miami 91
King, F. Gordon, Jacksonville 643
Klotz, Solomon D., Orlando 38
Lamar, Carlos P., Miami 167
Lischkoff, Mozart A., Pensacola 491
Lisenby, Amsie H., Panama City 727
Logan, William P., Lakeland 422
Lott, Herbert B., Tampa 407
Ludwig, B. L., Miami 578
Lyerly, James G., Jacksonville 264
MacGregor, John B., Jacksonville 416
McGee, W. Ambrose, West Palm Beach 741
Marcus, Nathan L., Tampa 101
Mixter, William Jason, Boston 159
Morse, George W., Pensacola 338
Musser, William L., Winter Park 589
Newton, Virgil M., Jr., Tampa 179
Ochsner, Alton, New Orleans 815
Packard, John M., Pensacola 30
Parks, Lorenzo L., Jacksonville 507
Pearson, R. Judson, Jr., Jacksonville 416
Preston, Edwin P., Miami 652
Rogers, H. Milton, St. Petersburg 495
Rorebeck, Curtis G., Tampa 407
Sackett, Walter W., Jr., Miami 21
Scheinberg, Peritz, Miami 817
Schmitt, George F., Jr., Miami 411
Schwartz, Steven O., Chicago 327

(Continued on page 958)

Founded 1927 by
Charles A. Reed

and **NEUROLOGY INSTITUTE**

For Diagnosis and Treatment of Nervous and Mental Disorders, Alcoholism and Drug Habituation

Member of American Hospital Association
Florida Hospital Association
American Psychiatric Hospital Institute

Miami Sanatorium Serves all Florida and the Federal Agencies
Information on Request

North Miami Avenue at 79th Street
Miami, Florida

Phone: 7-1824
84-5384

(Continued from page 957)

Sheppard, Ben J., Coral Gables 21
Snyder, John W., Miami 652
Stage, John T., Jacksonville 173
Stearns, C. R., Lakeland 655
Stillman, Sidney, Jacksonville 25
Stubbart, F. James, Orlando 505
Sumner, Wilbur C., Jacksonville 414
Sweany, Henry C., Tampa 37
Taylor, J. Champneys, Jacksonville 173
Trice, William W., Jr., Tampa 334
Turnley, William H., Ocala 729
Waisman, Morris, Tampa 249
Walter, William A., Jacksonville 580
Weiland, Arthur H., Miami 487
Williams, John W., Lakeland 655
Wilson, Scottie J., Fort Lauderdale 403
Windham, Samuel W., Dothan, Ala. 820

Abstracts

Alexander, Robert M., Lake City 185
Allen, Ralph, Miami 427
Anderson, James R., West Palm Beach 594
Bedell, Sullivan G., Jacksonville 831
Beidleman, Barkley, Pensacola 429, 835, 891
Belle, Martin S., Miami 427
Bone, Frank C., Orlando 426, 428
Butt, Arthur J., Pensacola 428, 512, 592, 832, 891
Cassel, Chester, Miami 426, 428, 833
Cooke, Francis N., Miami 835
Coplan, Milton M., Miami 107, 351
David, J. K., Jr., Jacksonville 107
Davis, H. Clinton, Miami 892
Day, Samuel M., Jacksonville 833
Droege, Frederick D., Sarasota 744
Edwards, Thomas M., Tampa 185
Evans, Elwyn, Orlando 745
Fitzgerald, Willard L., Miami 595
Fitzpatrick, Raymond J., Orlando 426, 834, 892
Forbes, Sherman B., Tampa 185, 513
Fox, Sidney, Miami 427
Frazier, Truett H., Orlando 595
Glanton, James B., Orlando 426, 594, 892
Goddard, David W., Daytona Beach 513
Griffitts, James J., Miami 595
Hahn, Theodore F., Jr., DeLand 513
Hayward, Joseph C., Orlando 426, 594, 892
Hollender, Abraham R., Miami Beach 513
Irwin, Thomas M., Jacksonville 745
Isaacs, Ivan, Jacksonville 834
King, F. Gordon, Jacksonville 833, 892
Levin, Nathaniel M., Miami 593
Lyerly, James G., Jacksonville 427, 833
McDonald, John M., Jacksonville 41, 429
McLemore, Carl S., Orlando 832
Melvin, Perry D., Miami 107, 351
Nelson, Thomas F., Tampa 833
Orr, Louis M., II, Orlando 426, 594, 834, 892
Perlmutter, Irwin, Miami 350
Phillips, Roger E., Orlando 831
Pyle, Frank J., Orlando 41
Rezek, Philipp R., Miami 351
Rich, Maurice, Miami 427, 513
Rogers, H. Milton, St. Petersburg 594
St. John, Joseph H., Jacksonville 428
Sayet, Maxwell M., Miami Beach 513
Scheinberg, Peritz, Miami 427, 592, 744
Seiler, Hawley H., Tampa 512
Smith, Donald W., Miami 351, 595
Strain, Richard E., Miami 834
Thomas, Merrick D., Jr., Miami 595
Waisman, Morris, Tampa 428
Wilson, J. Frank, Jacksonville 351
Woods, Frank M., Miami 107, 351

HIGHLAND HOSPITAL, INC.

FOUNDED IN 1904

Asheville, North Carolina

AFFILIATED WITH DUKE UNIVERSITY

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a sixty-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D.,
Diplomate in Psychiatry
Medical Director

ROBT. L. CRAIG, M.D.,
Diplomate in Neurology and Psychiatry
Associate Director

You'd see a good-sized gallery

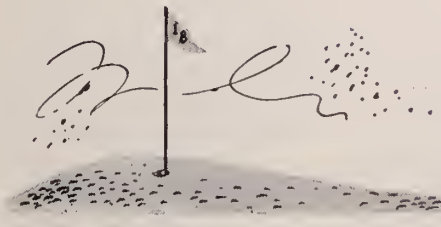
. . . with all the patients who represent the 44 uses for short-acting

Nembutal®

WHAT YARDSTICK DO YOU USE TO DETERMINE the drug you write on your prescription? If the drug is a barbiturate—such as short-acting NEMBUTAL (Pentobarbital, Abbott)—you can measure it, compare it and sum it up in these four short sentences:

1. *Short-acting* NEMBUTAL *can produce any desired degree of cerebral depression—from mild sedation to deep hypnosis.*
2. *The dosage you need is small—only about half that of many other barbiturates.*
3. *There's less drug to be inactivated, shorter duration of effect, wide margin of safety and usually no morning-after hangover.*
4. *In equal oral doses, no other barbiturate combines quicker, briefer, more profound effect.*

Perhaps that's why—after 23 years, 598 published reports and more than 44 clinical uses—you'll find more and more prescriptions call for NEMBUTAL. Abbott



1-161

The Right to *Choose* . . . .

CORNERSTONE OF AMERICAN LIBERTY

Hospital Expense Plans

AS long as Americans keep the right to choose — their church, their political party, their doctor and their hospital — freedom must prevail.

Medical-Surgical Expense Plans

We are proud that hundreds of thousands of Americans have freely chosen the protection afforded them by PENNSYLVANIA LIFE'S liberal, low-cost health insurance plan.

Paycheck Protection Plans

Pennsylvania Life
HEALTH & ACCIDENT **Insurance Company**

FOUNDED 1890

HOME OFFICE: PHILADELPHIA 5, PA.

Life Insurance Plan

19 District Offices in Florida

Miami	Executive Office	3028 Biscayne Blvd.	
	Downtown	1210 Pacific Building	
	Southwest	1260 S. W. 22nd Street	
	Little River	8340 N.E. Second Ave., Suite 245	
	Coral Gables	3028 Biscayne Blvd.	
	Miami Beach	206 Harvey Building	
St. Petersburg		509 White Building	
Lakeland		206 Marble Arcade	
West Palm Beach		305 Citizens Building	
Orlando		209 Slayton Building	
Fort Lauderdale		521½ South Andrew Avenue	
Jacksonville		303 Clark Building	
Tampa		228 Cass Street Arcade Building	
Sarasota		237 Main Street, Room 15	
Fort Pierce		Florida Bank Building, Room 34	
Daytona Beach		116½ Orange Avenue	
Tallahassee		429 Centennial Building	
Panama City		142 Harrison Avenue	
Pensacola		501 Theisen Building	

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
da Medical Association	Frederick K. Herpel, W. Palm Bch.	Samuel M. Day, Jacksonville	Hollywood, Apr. 25-28, '54
da Medical Districts	John D. Milton, Miami	Council Chairman	
Northwest	Francis M. Watson, Marianna	George S. Palmer, Tallahassee	Tallahassee, 1953
Northeast	William C. Thomas, Jr., Gainesville	Thomas C. Kenaston, Cocoa	St. Augustine, 1953
Southwest	Emmett E. Martin, Haines City	Clyde O. Anderson, St. Petersburg	Tampa, 1953
Southeast	Erasmus B. Hardee, Vero Beach	Russell B. Carson, Ft. Lauderdale	West Palm Beach, 1953
da Specialty Societies			
emy of General Practice	Raymond R. Killinger, Jacksonville	Leo M. Wachtel, Jr., Jacksonville	Hollywood, Apr. 25, '54
ry Society	James H. Putman, Miami	Lewis Palay, Miami Beach	" "
hesiologists, Soc. of	Adelbert F. Schrimer, Orlando	Breckenridge W. Wing, Orlando	" "
ter, Am. Coll. Chest Phys.	Nathaniel M. Levin, Miami	Hawley H. Seiler, Tampa	" "
. and Syph., Soc. of	Morris Waisman, Tampa	Joseph A. J. Farrington, Jacksonville	" "
h Officers' Society	Lorenzo L. Parks, Jacksonville	Clarence L. Brumback, W. Palm Beach	" "
trial & Railway Surgeons			" "
ology & Psychiatry	William H. McCullagh, Jacksonville	Roger E. Phillips, Orlando	" "
nd Gynec. Society	Ferdinand Richards, Jacksonville	J. Champneys Taylor, Jacksonville	" "
hal. & Otol., Soc. of	Mozart A. Lischkoff, Pensacola	Carl S. McLemore, Orlando	" "
pedic Society	Herschel G. Cole, Tampa	Newton C. McCollough, Orlando	Tampa, Oct., '53
ologists, Society of	Alfred E. Cronkite, Fort Lauderdale	Clarence W. Ketchum, Tallahassee	Hollywood, Apr. 25, '54
tric Society	Charlotte C. Maguire, Orlando	Wesley S. Nock, Coral Gables	" "
ologic Society	John J. Cheleden, Daytona Beach	George Williams, Jr., Miami	" "
logical Society	Nelson T. Pearson, Miami	Hugh G. Reaves, Sarasota	" "
gical Society	Frank M. Woods, Miami	David W. Goddard, Daytona Beach	" "
da—			
sic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 6, '53
od Banks, Association	Donald W. Smith, Miami	Mr. J. M. Potts, Miami	
ie Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Miami, Dec. 3, '53
ie Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Webster Merritt, Jacksonville	
ncer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Hollywood, Apr. 25, '54
ntal Society, State	L. M. Schulstad, D.D.S., Bradenton	B. S. Carroll, D.D.S., Jacksonville	Daytona Beach, April '54
art Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
spital Association	Mr. T. F. Little, Daytona Beach	Mr. Tracy B. Hare, Miami	Miami, Nov. '53
dical Examining Board	Ralph B. Spires, DeFuniak Springs	Homer L. Pearson, Jr., Miami	Jacksonville, June 28-30, '53
dical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 22-27, '53
rses Association, State	Mrs. Mary Livingston, W. P. Beach	Mrs. Idalyn Lawthon, Tampa	Tampa, Nov. '53
rmaceutical Association, State	Mr. Clyde Morris, Daytona Beach	Mr. R. Q. Richards, Ft. Myers	
blic Health Association	Mr. Angus Laird, Tallahassee	Mr. Fred B. Ragland, Jacksonville	Tampa, Oct. 22-24, '53
ideau Society	Hawley H. Seiler, Tampa	John G. Chesney, Miami	
berculosis & Health Assn.	Leffie M. Carlton, Jr., Tampa	Mrs. L. C. Conant, Fort Myers	
man's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	Hollywood, Apr. 25-27, '54
ican Medical Association	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	New York, June 1-5, '53
M.A. Clinical Session	Louis H. Bauer, Hempstead, N. Y.	Geo. F. Lull, Chicago	St. Louis, Dec. '53
ern Medical Association	Walter C. Jones, Miami	Mr. C. P. Loranz, Birmingham	Atlanta, Oct. 26-29, '53
ma Medical Association	D. O. Morgan, Gadsden	Douglas L. Cannon, Montgomery	Mobile, Apr. 15-17, '54
ia, Medical Assn. of	Wm. P. Harbin, Jr., Rome	David Henry Poer, Atlanta	Macon, 1954
Hospital Conference	Charles W. Holmes, Memphis, Tenn.	Pat Groner, Pensacola	Atlanta, Apr. 6-8, '54
eastern Allergy Assn.	Walter Rucks, Memphis, Tenn	Kath. B. MacInnis, Columbia, S. C.	
eastern, Am. Urological Assn.	Russell B. Carson, Fort Lauderdale	Sidney Smith, Raleigh, N. C.	Palm Beach, April, '54
eastern Surgical Congress	J. R. Young, Anderson, S. C.	B. T. Beasley, Atlanta	Birmingham, Mar. 8-11, '54
Coast Clinical Society	Hays Zieman, Mobile, Ala.	William Atkinson, Mobile, Ala	Mobile, Oct., '53

Index to

Volume XXXIX

Page 947

Proceedings of

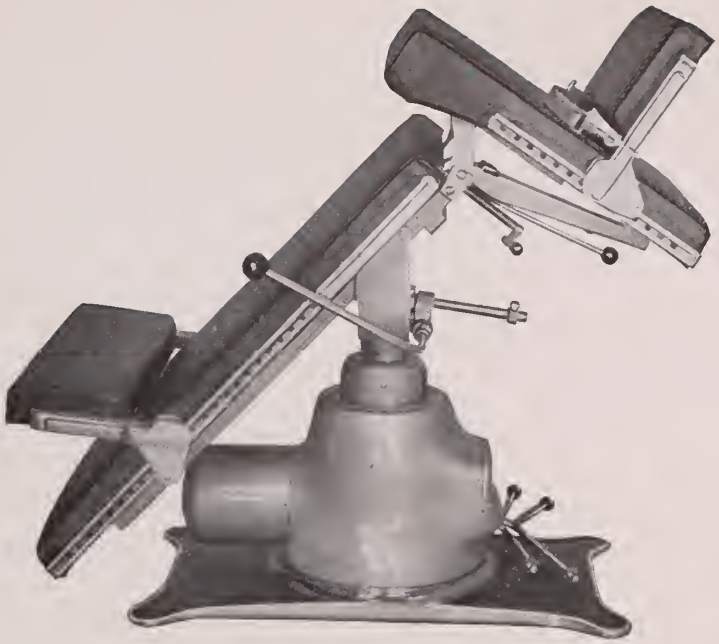
Seventy-Ninth Annual Meeting

Page 893

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS TOTAL	MEMBERS PAID	COUNCILOR
A	Bay	Harold E. Wager, M.D. Box 984 Panama City	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	1st Tuesday 7:30 P.M.	24	20	
	Escambia *Santa Rosa*	Alvin L. Stebbins, M.D. 621 N. O St. Pensacola	Paul F. Baranco, M.D. 608 Blount Bldg. Pensacola	2nd Tuesday 8:00 P.M.	88	100%	
	Franklin-Gulf	Photis J. Nichols, M.D. Apalachicola	Terry Bird, M.D. Apalachicola	Last Wednesday except Dec. & July	7	100%	A-1-54 Francis M. Watson, M.D. Marianna
	Jackson-Calhoun	Grayson C. Snyder, M.D. Floyd Bldg. Blountstown	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	19	18	
	Walton-Okaloosa	Edgar H. Myers, M.D. DeFuniak Springs	William D. Cawthon, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	17	100%	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		5	100%	
B	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	10	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	T. Bert Fletcher, Jr., M.D. 516 N. Adams St. Tallahassee	Quarterly 7:30 P.M.	59	54	
	Suwannee	Hiram B. Curry, M.D. Jasper	Edward G. Haskell, Jr., M.D. Branford	1st Saturday 9:30 A.M.	8	100%	A-2-55 George S. Palmer, M.D., Tallahassee
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		4	3	
	Taylor *Dixie, Lafayette*	Mark E. Adams, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	4	3	249
C	Alachua *Bradford, Gilchrist, Union*	F. Emory Bell, M.D. Box 113 Gainesville	Winston L. Summerlin, M.D. 111 S. W. 3rd St. Gainesville	2nd Tuesday 8:00 P.M.	46	42	
	Duval *Clay*	W. W. Rogers, M.D. 962 Main St. Jacksonville	John T. Stage, M.D. 2033 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	258	211	
	Marion *Levy*	Eugene G. Peek, Jr., M.D. Box 248 Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	28	22	B-3-54 William C. Thomas, Jr., M.D. Gainesville
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	12	11	
	Putnam	Bernard E. Kane, M.D. Box 216 Crescent City	James A. Long, Jr., M.D. 1001 Main St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
	St. Johns	John M. Canakaris, M.D. Box 295 Bunnell	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
	Brevard	Laurent L. LaRoche, M.D. 526 Brevard Ave. Cocoa	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	2nd Tuesday	25	23	
	Lake *Sumter*	John D. Bloom, M.D. Groveland	J. Basil Hall, M.D. Tavares	1st Wednesday 7:30 P.M.	27	25	B-4-55 Thomas C. Kenaston, M.D., Cocoa
	Orange *Osceola*	G. Tayloe Gwathmey, M.D. 417 E. Robinson Ave. Orlando	Andrew W. Townes, Jr., M.D. 717 N. Magnolia Ave. Orlando	3rd Wednesday 8:00 P.M.	169	165	
	Seminole	Wade H. Garner, M.D. Box 219 Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	18	100%	
	Volusia *Flagler*	Morris B. Seltzer, M.D. 614 N. Peninsula Dr. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	83	74	690
D	Hillsborough	Arthur R. Knauf, M.D. 706 Franklin St. Tampa	Julien C. Pate, Jr., M.D. 1105 First Nat. Bk. Bldg. Tampa	1st Tuesday 8:00 P.M.	177	162	
	Manatee	William D. Sugg, M.D. Bradenton Bank Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	21	19	
	Pasco-Hernando-Citrus	Karl T. Humes, M.D. Box 157 Bushnell	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	18	100%	C-5-55 Clyde O. Anderson, M.D., St. Petersburg
	Pinellas	Everett M. Harrison, M.D. 1601 N. Ft. Harrison Ave. Clearwater	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Mon. Even Mo. 1st Fri. Odd Mo. 6:00 P.M.	200	196	
	Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	Melvin M. Simmons, M.D. 816 Florasota Gardens Sarasota	2nd Tuesday 8:30 P.M.	47	39	
	DeSoto-Hardee-Highlands-Glades	Wesley S. Pyatt, M.D. Bowling Green	Merle C. Kayton, M.D. Wauchula	2nd Tuesday 8:00 P.M.	24	100%	
	Lee-Charlotte-Collier-Hendry	Ernest Bostelman, M.D. 201 Pythian Bldg. Fort Myers	Harry Fagan, Jr., M.D. 310 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	29	100%	C-6-54 Emmett E. Martin, M.D. Haines City
	Polk	Jere W. Annis, M.D. Box 1021 Lakeland	James T. Shelden, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	96	93	612
D	Indian River	John P. Gifford, M.D. 1625 Osceola Blvd. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	7	
	Palm Beach	Graham W. King, Jr., M.D. Box 505 Delray Beach	David A. Newman, M.D. 175 Bradley Pl. Palm Beach	3rd Monday 8:00 P.M.	123	100%	D-7-54 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	John T. McDermid, M.D. 337 N. 4th St. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	16	15	
	Broward	Claus A. Peterson, M.D. 312 Blount Bldg. Ft. Lauderdale	James M. Weaver, M.D. Box 4084 Ft. Lauderdale	4th Tuesday 8:00 P.M.	96	90	
	Dade	Ralph W. Jack, M.D. 1700 Biscayne Blvd. Miami	Walter W. Sackett, Jr., M.D. 2500 Coral Way Miami	1st Tuesday 8:30 P.M.	632	516	D-8-55 Russell B. Carson, M.D. Fort Lauderdale
	Monroe	Joseph L. G. Lester, Jr., M.D. 422 Fleming St. Key West	Allen S. Shepard, M.D. 638 United St. Key West	2nd Thursday 8:00 P.M.	15	10	890

Total 2,441

Position Patients More Easily . . .



with a Ritter PROCTOLOGIC TABLE

Designed in cooperation with leading proctologists, only the Ritter Proctologic Table, Type 7, features automatic elevation of the leg section above the high line of the body section as the leg section is lowered from horizontal to vertical. As a result of this exclusive feature, an abdominal drop-out area is immediately created. The depth of the drop-out area can be easily adjusted.

Standard equipment includes adjustable headrest and kneerest with snap-lock adjustable leg strap on kneerest. The table is normally supplied with a hand lever tilt lock, as illustrated. A touch of the toe on the foot pedal and the motor-driven, hydraulically-operated base raises patients effortlessly, quietly from 29″ to 47″. Table tilts 55° head low and rotates 180°. Hip rest cushion and stirrups are available at slight additional cost. Foot lever tilt optional. Hand wheel tilt at slight additional cost. Standard silver metallic finish and black Masland Durasol upholstery. Ask us for a demonstration now.

MEMBER

AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A.

Anderson Surgical Supply Co.

Established 1916

Telephone 5-2560
40-42 W. DUVAL STREET
P. O. Box 1799
JACKSONVILLE, 1, FLORIDA

Telephone 2-8504
MORGAN AT PLATT
P. O. Box 1223
TAMPA 1, FLORIDA

Telephone 7-4589
21 3rd STREET N.
ST. PETERSBURG, FLORIDA

NEW YORK ACADEMY OF MEDICINE
2 E 103RD ST
NEW YORK N Y 29
2
J C-E

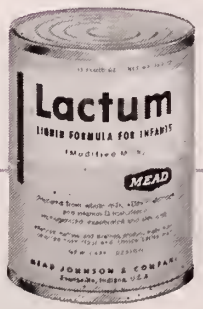
uncomplicated progress...

Tolerance of feedings	Good
Incidence of digestive disturbances	Low
Growth response	Satisfactory
Discontinuation of night feeding	Early
Health and development	Excellent

The uncomplicated nutritional progress[1] of infants fed Lactum® speaks for its sound rationale. Lactum is Mead's liquid formula made from whole milk and Dextri-Maltose.® It provides generous milk protein for sturdy growth and sound tissue structure, with sufficient calories to spare protein and meet the infant's energy needs.

Lactum is convenient and easy to prepare—simply mix equal parts of Lactum and water for a formula supplying 20 calories per fluid ounce.

1. Frost, L. H., and Jackson, R. L.: J. Pediat. 39: 585-592, 1951.



Lactum

MEAD JOHNSON & COMPANY
Evansville 21, Ind., U. S. A.

MEAD

Local Representative: Roger J. McElroy, 3181 McDonald Street, Coconut Grove 33, Florida, 4-4124.

The New York Academy of Medicine

DUE IN TWO WEEKS UNLESS RENEWED.
NOT RENEWABLE AFTER 6 WEEKS

DATE BORROWED	BORROWER
NOV 9 1954	USDA Brook
NOV 9 1954	